ADULT SOCIAL SERVICES POLICY OVERVIEW COMMITTEE

Tuesday, 22nd September, 2009

9.30 am

Council Chamber, Sessions House, County Hall, Maidstone

Members are asked to note the earlier start time of this meeting

AGENDA

ADULT SOCIAL SERVICES POLICY OVERVIEW COMMITTEE

Tuesday, 22 September 2009 at 9.30 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Theresa Grayell**
Telephone **01622 694277**

Tea/Coffee will be available 30 minutes before the meeting

Membership (13)

Conservative (11): Mr P W A Lake (Chairman), Mr K Pugh (Vice-Chairman), Mrs A D Allen, Mr R Brookbank, Mrs P Cole, Mr N Collor, Mr J Cubitt, Mr D A Hirst, Mr M J Jarvis, Mr J E Scholes and Mr C P Smith

Labour (1): Mr L Christie

Liberal Democrat (1): Mr S J G Kooware e

UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

The Committee has the option of breaking for lunch and continuing its business afterwards, if the weight of business dictates. The timing of the meeting will be determined on the day by the Chairman. All timings shown on this agenda are approximate.

Item No

A.COMMITTEE BUSINESS

A1 Substitutes

A2 Declarations of Members' Interest relating to items on today's agenda

A3 Minutes of the meeting held on 15 July 2009 (Pages 1 - 22)

A4 Chairman's Announcements

B. ITEMS FOR CONSIDERATION

B1 Potential to Refocus and Restructure the Overview and Scrutiny Function (Pages 23 - 32)

10.00 - 11.00 am Presentation - 'Shaping the Future of Care Together' - The Green Paper on Care and Support

B2 Adult Social Services Budget Monitoring 2009/10 - First Quarterly Report (Pages 33 - 64)

B3 Towards 2010 - Annual Report (Pages 65 - 82)

B4 End of Year Results for Performance 2008 - 09 (Pages 83 - 86)

B5 'Independence, Wellbeing and Choice' Inspection (Pages 87 - 98)

B6 Kent Adult Social Services Positive Risk Management Policy for staff carrying out Community Care Assessments (Pages 99 - 128)

B7 Draft Annual Performance Report 2008/09

C. SELECT COMMITTEE WORK

C1 Update on Select Committee Work (Pages 129 - 130)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

Monday, 14 September 2009

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

ADULT SOCIAL SERVICES POLICY OVERVIEW COMMITTEE

MINUTES of a meeting of the Adult Social Services Policy Overview Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 15 July 2009.

PRESENT: Mr P W A Lake (Chairman), Mrs A D Allen, Mr R Brookbank, Mr L Christie, Mrs P Cole, Mr N Collor, Mr J Cubitt, Mr D A Hirst, Mr M J Jarvis, Mr K Pugh, Mr J E Scholes, Mr C P Smith and Mr M J Vye (Substitute for Mr S J G Koowaree)

ALSO PRESENT: Mr M J Angell and Mr G K Gibbens

IN ATTENDANCE: Mr O Mills (Managing Director - Adult Social Services), Mr S Leidecker (Director of Operations) and Miss T Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

3. Election of Vice-Chairman
(Item A2)

Mrs A D Allen proposed and Mr C P Smith seconded that Mr K Pugh be elected Vice-Chairman of the Committee.

Agreed without a vote

4. Minutes of the Meetings held on 1 April and 25 June 2009
(Item A4)

RESOLVED that the Minutes of the meetings held on 1 April and 25 June 2009 are correctly recorded and that they be signed by the Chairman. There were no matters arising.

5. Meeting Dates for 2009 - 2010
(Item A5)

RESOLVED that the dates reserved for the Committee's meetings for the remainder of 2009 and 2010 be noted, as follows:-

Tuesday, 22 September 2009
Tuesday, 17 November 2009

Wednesday, 13 January 2010
Tuesday, 30 March 2010
Friday, 25 June 2010
Tuesday, 21 September 2010

Tuesday, 16 November 2010

All meetings will start at 10.00 am at County Hall and may run into the afternoon if the weight of business dictates.

6. Chairman's Announcements
(Item A6)

(1) The Chairman welcomed Miss Jennifer Powell, a sixth form pupil at the Westlands School in Sittingbourne, who was visiting the Democratic Services Unit for a week's work experience.

(2) He announced the receipt of the Care Quality Commission's (CQC) report of its inspection of Kent Adult Social Services in March, "Independence, Wellbeing and Choice". Mr Gibbens added his thanks and appreciation to KASS officers and asked that these be passed onto the staff who had taken part in the inspection. He emphasised that only one other shire county had achieved the same level as Kent, and was delighted that Kent had performed so well against its peers, as this demonstrated its commitment to strong service delivery. He said it was good that both the service delivery and capacity to improve had scored well as this illustrated Kent's commitment to constant improvement. All POC Members would be sent a copy of the Inspector's report, and an item would be included on September's agenda to allow Members the opportunity to debate it fully.

(3) The Chairman referred to the Government Green Paper "Shaping the Future of Care Together" which Mr Mills explained had been published on 14 July 2009. All POC Members were given a summary of the paper and all would be sent a copy of the full Green Paper. An item on the Green Paper would be included in the POC's September agenda, to allow Members the chance to debate it fully and contribute views before the end of the consultation period in November 2009.

7. Presentation - the Active Lives for Adults Programme (ALfA)
(Item)

(1) Mr Mills presented a series of slides *(which are appended to these Minutes)* setting out the work of KASS around Active Lives for Adults and new ways of working which were currently being developed, particularly Self Directed Support (SDS). The self-generated major restructure of the directorate which had taken place over recent months was closely linked to the changing methods of service delivery and had been undertaken to support these new approaches.

(2) Mr Mills, Mr Gibbens and Mr Leidecker answered a number of questions from Members, and the following points were highlighted:-

(a) all new clients assessed by KASS would have a personal budget, and existing clients would gradually transfer to personal budgets;

(b) the nature of KASS's work, assessing and delivering services to meet individuals' needs, meant that change to a new delivery model would

necessarily be very gradual. Individual plans would allow service users maximum personal choice, so the patterns identified when referring to change would be general trends only. Clients would never all be using exactly the same ways of accessing services;

(c) the personal assistants who are employed by clients using personal budgets are not employed by KASS, but KASS staff would act as brokers/co-ordinators to ensure that local provision was sufficient to meet the needs of the local client population;

(d) when making changes to day centre services for clients with learning disabilities, full consultation was always undertaken to ensure that no-one was left without a service that they wanted and relied upon;

(e) the option of using direct payments would always remain a choice for clients and was never imposed upon them. Currently, some 2,300 clients were using direct payments;

(f) KASS staff have the responsibility to emphasise the importance of Criminal Records Bureau (CRB) checks and encourage vulnerable adults who are employing personal assistants via direct payments to undertake CRB checks on those people, but could not force them to undertake these;

(g) Personalised Care Plans (PCPs) would take account of the views of clients and their carer/s and seek to reach a compromise and satisfy both as far as possible if these views differed;

(h) it was the intention that area briefings for Members would continue, as these had been shown to be very useful in keeping local Members informed of service developments. By combining two neighbouring districts, briefings could be made more frequent;

(i) the range of services provided was vital in delivering ALfA, so KCC worked actively with transport providers and district councils as well as health partners. The KCC's 'Living Later Life to the Full' Policy Framework addressed this issue in more detail;

(j) social networks, companionship and good communication were also vital in giving support to clients who might otherwise become isolated and would allow them to live independently for as long as possible; and

(k) in response to a question, Mr Mills said he was confident that all measures possible had been put in place to address the swine flu pandemic. The Kent Resilience Forum, which included public health and NHS input, had a well-established procedure which would be used to address the pandemic. Mr Leidecker added that KASS had a dedicated Emergency Planning Officer who would ensure the needs of vulnerable adults are included in planning.

(3) RESOLVED that the information given in the presentation and in response to Members' questions be noted, with thanks.

8. 2008/09 Business Plan Outturn Report
(Item B1)

(Mr N Sherlock, Head of Planning and Public Involvement, and Ms E Matthews, Senior Planning Officer, were in attendance for this item)

(1) Mr Leidecker introduced the report and explained that the new format this year brought together business plan and finance outturn monitoring information. He outlined a number challenges in recording performance against business plan targets:-

(a) many scores were amber – “almost complete” – as they could not be converted to green until they were totally complete;

(b) some projects do not fit neatly into financial years but run over the year end, so will only show partial completion;

(c) this year’s performance had been achieved again the background of a major directorate restructure and a major inspection, both of which diverted much staff resources;

(d) some targets are addressed in partnership with KCC’s partners, and performance is not always just down to KCC; and

(e) KASS continued to maintain low levels of staff turnover and sickness.

(2) Mr Leidecker, Mr Sherlock and Mr Gibbens answered a number of questions from Members and the following points were highlighted:-

(a) the ‘traffic light’ system could be viewed as being restrictive, having only three bands. Amber indicates incomplete performance but also indicates room and need for on-going improvement, whilst scoring too many greens could lead to complacency;

(b) although it could be seen as crude, traffic lights allowed a like with like comparison between directorates and with other councils;

(c) alongside the traffic light system, it was vitally important to look at the number of successful outcomes for, and the satisfaction of, service users. What the public saw as good or bad was also very important;

(d) it was suggested that future reports could pick out the ‘red’ scores and give Members an update on the progress of them. This idea was supported; and

(e) a detailed explanation of how resources are allocated to address issues where performance scores red would be circulated to all POC Members.

(3) RESOLVED that the information given in the report and in response to Members’ questions be noted, with thanks.

9. 2009/10 Budget Monitoring Exception Report
(Item B2)

(1) Mr Leidecker introduced the report, which gave a very early indication of outcome, and said he was confident of achieving a balanced budget by the end of the 2009/10 financial year.

(2) In response to a question, he reassured Members that there was no evidence of service users being deterred from using domiciliary care services by the changes in pricing. Reduced take up of domiciliary care in recent years should be seen in the context of other initiatives which offered older people different benefits and choices. He added that whilst there had been some reduction, the activity and expenditure lines on domiciliary care still fluctuated and, overall, this area remained one of the most volatile parts of the KASS budget. KASS would continue to monitor the situation very closely.

(3) RESOLVED that the information given in the report be noted, with thanks.

10. Adult Social Services Directorate Annual Business Plan 2009 - 10
(Item B3)

(Mr N Sherlock, Head of Planning and Public Involvement, and Ms E Matthews, Senior Planning Officer, were in attendance for this item)

RESOLVED that the information given in the report be noted, with thanks.

11. Alcohol Strategy for Kent
(Item B4)

(Ms A Slaven, Director of Youth Services and Kent Drug and Alcohol Action Team (KDAAT) was in attendance for this item)

(1) Ms Slaven introduced the report and explained that the POC was being given a chance to feed into the consultation period, which had been extended to 19 September 2009, as all other POCs and many of KCC's partners had already done.

(2) Members welcomed the strategy generally, and thanked Ms Slaven's team for all the work put into it. In debate they expressed the following views:-

(a) more thought should be put into the prevention of alcohol related problems, not just the treatment of them;

(b) all generations – young people and their parents and grandparents – needed to be helped to understand the impact of alcohol misuse. Young people receiving information and training targeted at them often highlighted that their parents/grandparents drank more than they did. It was important not to overlook the extent to which adults also needed engaging and educating;

(c) national statistics showed that 70% of A&E admissions were related to alcohol misuse, and Members asked to be told the age profile of this number. Ms Slaven confirmed that statistics were available and would be sent to Members;

(d) a large number of young people coming into KCC care did so as a result of alcohol or drug misuse, which inevitably led to substantial costs for the KCC, and the County Council should be able to identify statistics for the number of places and the costs of them;

(e) when investigating and dealing with issues relating to misuse, the importance of a methodical approach was emphasised; and

(f) as drug and alcohol misuse issues often shared and competed for the same limited resources, the importance of addressing alcohol issues should not be allowed to become overshadowed.

(3) RESOLVED that:-

(a) the Alcohol Strategy be welcomed, and the officers involved in its preparation be thanked and congratulated; and

(b) Members' comments, as set out in paragraph 2 above, be included in the consultation exercise.

12. Living Later Life to the Full: A Policy Framework
(Item B5)

(Ms D Exall, Head of Strategic Policy, was in attendance for this item)

(1) Ms Exall and Mr M J Angell, the KCC's Older People's Champion, introduced the report and explained that the POC's comments on and endorsement of the framework was being sought. Mr Angell emphasised that the Framework related to all directorates and was being considered by all POCs. Ms Exall said how useful the POCs had been as a mechanism for seeking Members' views.

(2) Ms Exall and Mr Angell answered a number of questions from Members and the following points were highlighted:-

(a) a full and active life depended on much more than good social care, and transport, health, social networks and adult education were all cited as other vital elements;

(b) transport problems were not limited to rural areas; the availability of evening and weekend services also presented problems;

(c) adult education needed to be available, accessible and affordable;

(d) the Framework and its benefits would need to be applied across the whole county, with no pockets or gaps in coverage;

(e) Members should champion the better use of resources which KCC had control of or had access to, for the benefit of both older and younger people. For example, KCC school buses could be used for an evening service where a commercial bus company was reluctant to run a lightly-used service, and library buildings could remain open for longer hours to provide meeting places for social networking;

(f) it was important to make optimum use of the resources and services run by KCC's partners and other bodies;

(g) a good interface between older and younger people was important and would give great benefits but was a challenge to achieve; and

(h) goodwill and potential funding support were available but linking them up needed a co-ordinator. KCC could consider whether or not it was able to offer staff to help co-ordinate services.

(3) RESOLVED that:-

(a) the framework be welcomed and endorsed, and the production team congratulated for all the work put into it; and

(b) Members' comments, as set out in paragraph (2) above, be taken into account as part of the consultation exercise.

13. Valuing People Now
(Item B6)

(Mr D Watson, Valuing People Now Delivery Manager, was in attendance for this item)

(1) Mr Watson introduced the report and explained that Valuing People Now was an initiative similar to Living Later Life in the Full in the breadth of issues it covered but was for people with learning disabilities. Mr Watson explained that his post had been created with the aim of helping to establish links between KCC directorates and with partner organisations and other bodies.

(2) The accessibility of transport was an important issue for people with learning disabilities and other special needs, and it was emphasised that funding for accessible transport initiatives should be sought and exploited wherever possible.

(3) Partnership Boards existed across Kent and these were run by people with learning disabilities for people with learning disabilities. Members who were more familiar with their work encouraged those Members who were not to find out about and attend these meetings, and Mr Watson undertook to provide meeting dates to POC Members.

(4) RESOLVED that the information given in the report be noted, with thanks.

14. Update on work to address Climate Change issues
(Item B7)

(Ms C Mckenzie, Sustainability and Climate Change Manager, was in attendance for this item)

(1) Ms Mckenzie introduced the report and thanked officers from KASS who had been involved in the work towards the KCC achieving ISO 14001 accreditation. She explained that Kent was one of the largest county councils to achieve this accreditation.

(2) Ms Mckenzie answered a number of questions from Members and the following points were highlighted:-

(a) issues beyond KCC's control which were identified by the 'Climate Change' and 'Water and Waste Water' Select Committees, both in 2006, were still very much on the Climate Change agenda. A Water Demand Management Group had been established, with KCC taking a lead role working with district councils and water companies. This Group worked on projects seeking to change attitudes to water usage and was pressing for national water consumption targets to be set; and

(b) systems design to re-use grey water were difficult to build into existing developments so were more economical to plan and include in new buildings. However, this and a new sustainable construction policy were being developed for KCC's property portfolio. The county's schools had been particularly keen to be involved in green projects.

(3) RESOLVED that:-

(a) the information given in the report and in response to Members' questions be noted, with thanks; and

(b) the proposed next steps for KASS, outlined in Section 6 of the report, be agreed.

15. Update on Select Committee Work
(Item C1)

(1) Miss Grayell introduced the report and highlighted two topics for Select Committee reviews – 'Safeguarding and Adult Protection' and 'Dementia' - which had been proposed by the POC for inclusion in the work programme.

(2) Members expressed disappointment at the ongoing delay in being able to start new Select Committee work, caused by the delay in the Policy Overview Co-ordinating Committee (POCC) being able to meet to consider and establish the new work programme.

(3) RESOLVED that:-

(a) the successful outcome of the Autistic Spectrum Disorder Select Committee work, and the welcome given to the completed report, be noted; and

(b) the process for preparing a new Select Committee Topic Review Programme, and the topics already put forward from this POC's work area, be noted, and Members' disappointment at the delay in agreeing a work programme and starting new Select Committee work be placed on record.

This page is intentionally left blank

Kent Adult Social Services

The Active Lives for Adults (AlFA) programme

Oliver Mills

15 July 2009

www.kent.gov.uk/socialcare
social.services@kent.gov.uk
08458 247 100

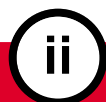
Kent County Council

What we do …

- Care and support
  - People with community care needs
  - Older people
  - People with learning disabilities
  - People with physical disabilities
  - People with sensory disabilities
  - Mental health
- Support for carers
- Safeguarding vulnerable adults
- Supporting People
- Gypsy and traveller sites

ii

www.kent.gov.uk/socialcare social.services@kent.gov.uk ☎ 08458 247 100



How we do it …

- Assess needs
- Commission care and support
  - In-house services
  - Independent sector
- Working with partners including health

www.kent.gov.uk/socialcare social.services@kent.gov.uk 08458 247 100

Kent County Council

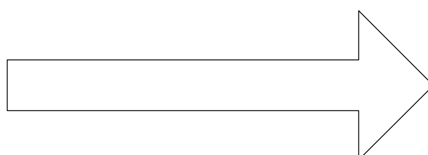
Putting People First

www.kent.gov.uk/socialcare
social.services@kent.gov.uk
08458 247 100
Kent County Council

Change Programme

- The Good Day Programme
- The Older Person’s Services Modernisation Workstream
- Whole Systems Demonstrator Programme
- Better Homes, Active Lives
- FAME (Flexible and Mobile Engagement)
- Ecommerce, E tendering, Client billing
- The Self Directed Support Project

www.kent.gov.uk/socialcare
social.services@kent.gov.uk
08458 247 100
Kent County Council

Old model		New Model
Residential Care		Sheltered Housing Living Independently
Domiciliary Care		Enablement Personal Assistant
Day care		Adult Education Leisure Centre
Day Opportunities Service		Employment

www.kent.gov.uk/socialcare
social.services@kent.gov.uk
08458 247 100
Kent County Council

Self Directed Support (SDS)

How?

- Directorate Restructure
- Alignment with Health
- Locality Based Services
- Diverse and Thriving Market

SDS – July

- Management restructure completed
- Phase 2 – consultation complete/all staff aware of their new post
- Personal Budgets being tested
- Kent Contact and Assessment Service (KCAS) goes live
- Enablement services countywide
- Brokerage pilots up and running

www.kent.gov.uk/socialcare social.services@kent.gov.uk 08458 247 100
Kent County Council

SDS – October

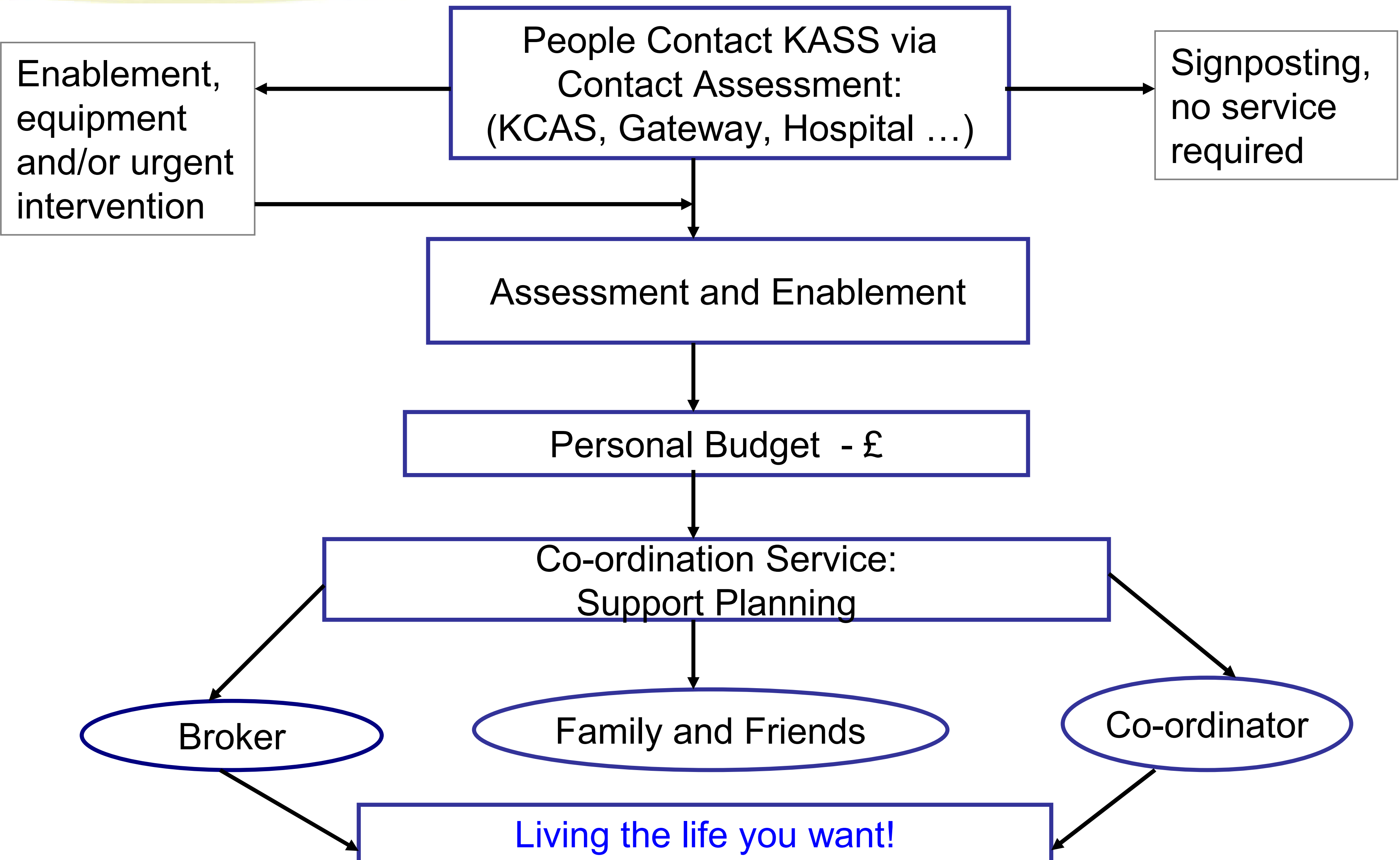
- New structures fully live
- Brokerage available countywide (KASS co-ordination and external brokerage)

SDS - After October

Reviewing, evaluating and improving

Resource Allocation System (RAS)

Diverse and thriving market


Kent Adult Social Services
People Contact KASS via Contact Assessment: (KCAS, Gateway, Hospital …)
Enablement, equipment and/or urgent intervention
Signposting, no service required
Assessment and Enablement
Personal Budget - £
Co-ordination Service: Support Planning
Broker
Family and Friends
Co-ordinator
Living the life you want!
www.kent.gov.uk/socialcare
social.services@kent.gov.uk
08458 247 100
Kent County Council

Why have we done this?

So that people can:

- Make their own choices
- Have control over their own support
- Live life as they want

www.kent.gov.uk/socialcare social.services@kent.gov.uk 08458 247 100
Kent County Council

This page is intentionally left blank

By: Alex King, Deputy Leader

To: Adult Social Services Policy Overview Committee
22 September 2009

Subject: **POTENTIAL TO REFOCUS AND RESTRUCTURE THE OVERVIEW AND SCRUTINY FUNCTION**

Classification: Unrestricted

---

1. Context

This paper represents current thinking from a variety of sources to develop a recommendation to full Council in October. The paper needs to be seen in the context of:

a) the emerging Strategy for Localism for the County Council and the various models and Frameworks for Localism being established across the County in conjunction with our Partners;

b) the development of the Member role(s) and County Council's application for the South East Employers Organisation Member Development Charter;

(c) implementation of the recommendations arising from the Informal Member Group: Member Information;

(d) the opportunities, working in partnership with Borough/District colleagues that may exist to pool the resources supporting Overview and Scrutiny across the County and to agree shared work programmes on issues which will add value without duplication to the communities which we all serve;

(e) the emerging scrutiny roles for which legislation/regulations have been published including Scrutiny of the Crime and Disorder Reduction Partnerships; and

(f) the scrutiny of the public sector bodies advocated in the consultation document "Strengthening Local Democracy".

2. Overview and Scrutiny – the Key Challenges

(1) As the Strategic Authority for Kent the County Council has a unique community leadership role. The challenge to Members is to:-

- Lead the provision of public services in the area;
- Engage with local communities, tiers of local government and stakeholders;
- Define with them the future of the locality; and

- Achieve the strategies and visions which people agree.

(2) That is what the best Councils are doing and their legitimacy for the future will derive from their role as democratic bodies.

(3) All Members of all parties, not just the Executive, have a role in community leadership.

(4) Scrutiny was initially seen to provide challenge to the Council's own service performance. That remains one aspect of the role, but much of the most effective work of scrutiny bodies has involved engagement with the wider community and across all public service issues. It is now incumbent upon the County Council to develop imaginative forms of engagement, to involve local people, service users and others in scrutiny. This is a wider conversation that scrutiny can lead across the county.

3. Challenges

(1) The challenges are as follows:-

- Widening the engagement and understanding of elected Members in effective Partnership working;
- Bringing the knowledge of local issues and communities which elected Members have to service providers involved in Partnerships;
- Holding the leadership of Strategic Partnerships across the public sector including local authorities to account.

(2) Effective Overview and Scrutiny must contribute to effective Partnership working. This can be done through:-

- Using scrutiny projects to bring Partner organisations together to find new ways of working jointly to tackle important local problems *(a good example of this was the work of the Health Overview and Scrutiny Committee in the summer of 2008 which facilitated a discussion between the Acute Hospital Trust, the Primary Care Trust, Dover District Council and the County Council to look at what could be the best outcome for Dover residents in terms of future healthcare provision)*;
- Raising the profile of scrutiny and its work priorities to enhance public understanding, and recognition – which has been described as 'championing the people of Kent'; and
- Building alliances with the Executive and other stakeholders to gain support for recommendations *(another good example is the work of the previous Council, the Select Committees on Autism Spectrum Disorder and Alcohol Misuse where all the Partners that had contributed to the recommendations which were not wholly in the gift of the County Council's Executive to deliver, were brought together before the Select Committee report was published to support the recommendations and take ownership for their delivery)*.

(3) It is important that the overview and scrutiny process adds value working towards positive recommendations and improvements and ensuring that it concentrates on what only scrutiny can do. It is not about duplicating the work of Regulators and Inspectorates. It is also about identifying the key issues behind the statistics – *e.g. widening the conversation to engage local people, service providers, neighbourhood users, communities, and the elected Members, verify problems, and develop ideas on how problems can be solved.*

4. Statutory Requirements

The County Council must have:-

(a) one scrutiny committee responsible for the scrutiny of Cabinet decisions and operating a "call in " procedure;

(b) a statutory Health Overview and Scrutiny Committee which encompasses Adult Social Care as well as NHS matters *(in the autumn it is understood that statutory guidance for local authorities and the NHS will be published setting out how overview and scrutiny of health services can be improved)*;

(c) at least one Committee must be designated as the Crime and Disorder Scrutiny on Committee *(these new powers which came into force on 1 April 2009 currently sit with the Communities Policy Overview Committee and are shortly to be the subject of some discussions on how it will operate with the Kent and Medway Police Authority)*; and

(d) statutory co-optees as required, primarily Church Diocesan representatives and Parent Governors who serve on the Cabinet Scrutiny Committee and the education related Policy Overview Committees.

5. Emerging Scrutiny - Scrutiny of the Crime and Disorder Partnerships

(1) Cabinet Members will be aware that the County Council's role in the scrutiny of the Crime and Disorder Reduction Partnership is currently in the Communities Policy Overview Committee.

(2) Ongoing discussions are taking place with partner organisations to identify how this might be delivered effectively across the democratically elected sector.

6. Consultation - "Strengthening Local Democracy"

(1) The first draft of a response to the consultation launched by Local Government Minister John Denham, on Strengthening Local Democracy has been considered earlier in the meeting.

(2) When launching the consultation, Local Government Minister John Denham, made reference to the proposal to give authorities greater scrutiny over:-

- Police strategies in Local Authority areas
- Fire and Rescue Authorities
- Local Authorities' delivery of high quality education provision

- Probation Authorities
- Job Centres Plus
- Utility companies
- Young People's education and skills issues

(3) As a consequence, bodies external to the scrutiny authority could be compelled to have regard to the recommendations of the scrutiny committee.

(4) This does present the real opportunity to pool all Overview and Scrutiny resources across the public sector and establish an independent body to scrutinise the decision makers of all these public sector bodies.

(5) The public will have the right to appeal to a scrutiny committee if they do not like the response to a petition

(6) A report on a process for written petitions and electronic petitions is to be the subject of a report to the Selection and Member Services Committee on 13 October and to the County Council on 15 October 2009. Every local authority is required to have a process for e-petitions. It will be important that the Cabinet, Chief Officer Group and the Head of Communications and Media Centre are fully aware of the petitions which have been logged and there closing dates and the mechanisms for responding to the petitioner(s).

(7) There is in a two tier area an opportunity for a petitioner to a Borough/District Council who remains dissatisfied with the response to refer the matter to the County Council. How this can best be organised is to be discussed with Borough and District Council colleagues at a meeting later on this month.

(8) The Strengthening Local Democracy consultation document also suggested:

(a) duty could be placed on local authority Chief Executives to ensure that Committee have adequate resources to carry out their work;

(b) that the Chairman of an Overview and Scrutiny Committee might be given the authority commensurate with a Cabinet post - *for example Essex County Council have created a lead role for one of their Scrutiny Chairman who chairs not only a Scrutiny Committee but also the Scrutiny Board (which comprises all the Scrutiny Chairmen and Area Forum Chairmen). The Scrutiny Chairmen have a designated room and the culture in Essex County Council has shifted to one of parity of esteem for scrutiny with the Executive. It was also evident from a discussion I have had with the Chairman of the Scrutiny Board that the culture of Essex County Council has changed and scrutiny is seen as an effective mechanism by the Council and Executive in adding value and outcomes for the residents of the County. Members may wish to consider whether the new model for Kent's Overview and Scrutiny function should strengthen the role of the Policy Overview Co-ordinating Committee to 'gate keep' and commission work for the Scrutiny Committees*; and

(c) there is also a suggestion that as part of the support required, Committees may call on expert advice from the public.

7. Cabinet Scrutiny Committee

(1) At the meeting of the Cabinet Scrutiny Committee on 21 July the Committee asked for a report back at its 23 September meeting on a range of issues including:-

(a) exploring how many authorities undertake pre-scrutiny;

(b) greater use of the media in helping to inform scrutiny;

(c) co-opting representatives to add rigour and robustness to the Overview and Scrutiny process; and

(d) the potential to strengthen the information made available to Members through the Forward Plan of Key Decisions.

(2) A number of local authorities responded to our request for information on pre-scrutiny. The responses indicated that the process we have for operating the existing Overview and Scrutiny structure of Committees is not dissimilar to the process described by other authorities as pre-scrutiny.

Forward Plan of Key Decisions

(4) One issue which may warrant attention is the possibility of strengthening the information in the Forward Plan of Key Decision and ensuring that the agenda setting process for each of the Council's Overview and Scrutiny Committees takes this into account.

Co-optees

(5) One view from Cabinet and the Cabinet Scrutiny Committee is that one of the ways of strengthening an Overview and Scrutiny process might be to have a pool of experts, advisors, representatives of organisations, voluntary sector or the public to call upon to assist the Overview and Scrutiny Committee for a specific issue. If this is decided by the County Council as an appropriate way forward the challenge will be is to establish an independent/impartial mechanism on how this can be achieved. Discussions have taken place with the Appointments Commission, Improvement and Development Agency (IDeA) and the South East Employers Organisation to see if they can assist but it seems unlikely. It has also been suggested that other South East county authorities who are also exploring this role to strengthen Overview and Scrutiny may be willing to establish a mechanism to support our respective overview and scrutiny processes.

(6) Members will be aware that the County Council process for establishing a Select Committee already includes consideration of the appointment of a co-opted expert/advisor who will be able to assist the Select Committee.

(7) Members will also be aware that Durham County Council have established from 1 April 2009 an Overview and Scrutiny structure which includes a scheme of co-option. Ongoing discussions will continue with Durham to assess how successful this scheme of co-optees has been.

Rapporteurs

(8) Members have expressed a wish in developing a rapporteur scheme whereby an elected Member(s) with a specific interest takes ownership for a piece of work, undertakes the research themselves and prepares a report. The Health Overview and Scrutiny Committee has expressed a wish to pilot a rapporteur scheme.

Involvement of the Media/Press in Scrutiny

(9) Members will be aware that the County Council has agreed a protocol for publicising and launching Select Committee reports (attached as an Appendix to this report).

(10) However, one of the issues which arose at the Cabinet Scrutiny Committee on 21 July 2009 was utilising the media and press more effectively. Having spoken to the Member who raised the issue the suggestion made is that when the Overview and Scrutiny Committees have identified their work programme then working with the Communication and Media Centre the views of the public should be sought through a formal process.

(11) Taking this one stage further it should be possible for the public to email in questions they would like asked as the meeting is progressing. This is an exciting proposal and would need careful consideration on how it is implemented/moderated. Members' views are sought.

8. Policy Overview Committees

Members are reminded that the County Councils current Overview and Scrutiny process gives non executive Members the ability to assist the Cabinet with Policy Development. At agenda setting meeting Members can make use of the Forward Plan to put an item on the POC agenda, also there is the opportunity for Cabinet Members to make the POC aware of developing policy areas which the POC could have an input into. Any Member may give notice that they wish an item to be considered at a POC meeting. It is important that Members make effective use of these powers to add value to the work of the County Council for the benefit of all Kent residents.

9. Duty to Involve

There is a correlation between the legislative framework around the "Duty to Involve" with the "Place Shaping Agenda", the development of the website, the concept of a "Virtual County Hall",(Kent Space- making Kent Work for You) (a concept whereby communities of interest through Social Networking find the County Council), the Citizens Panel, the Consultation Strategy, petitions and e-petitions, the emerging localism strategy which are all mechanisms, sources of information and evidence which can help to inform the Overview and Scrutiny function.

10. Timetable

(1) To meet the timetable for a report on the structure of the Overview and Scrutiny function to the County Council on 15 October 2009 I set out below a list of meetings which would give the opportunity to the majority of Members to contribute to this discussion.

Environment, Highways & Waste POC - **15 September**

Communities POC - **17 September**

C, F & E POCs - **18 September**

Adult Social Services POC - **22 September**

Cabinet Scrutiny Committee - **23 September**

Regeneration & Economic Development POC - **24 September**

Corporate POC - **25 September**

Health Overview and Scrutiny Committee - **2 October**

County Council - **15 October**

11. Recommendation

Members' views are requested before Cabinet Members make a recommendation to County Council.

Paul D Wickenden
Overview, Scrutiny and Localism Manager
01622 694486
paul.wickenden@kent.gov.uk

Appendix

Kent County Council

PUBLIC RELATIONS PROTOCOL FOR SELECT COMMITTEE REVIEWS AND REPORTS

This protocol has been written as a basis for all communications between Select Committee Members and the media. It will ensure that the corporate communications team is able to maximise opportunities for scrutiny to publicise its work and promote the transparency of the Council's decision-making process.

- All actions should be in accordance with the letter and spirit of the DCLG Code of recommended practice on local authority publicity.

- Media activity should be co-ordinated through the corporate communications team who will make arrangements and ensure that the appropriate Members are put forward, rather than Select Committee Members approaching the media direct to discuss the topic review.

- The Select Committee Chairman should be the official spokesperson for the review report, unless another more suitable spokesperson has been identified by the Chairman.

- Chairmen of Select Committees will be expected to attend or have attended media training.

- There is potential, on rare occasions, for conflict between scrutiny and cabinet on issues. Maintaining the professional reputation of the council in the eyes of the public is paramount and conflicting statements may make the council appear inept or divided. Care should be taken, on all sides, to avoid this situation from arising. But in such circumstances Corporate Communications would present factual information to the media fairly representing both the Scrutiny and Cabinet viewpoints.

- The corporate communications team should be advised of any media enquiries received by Select Committee Members to offer guidance and help if required and to monitor responses.

- Press releases for Select Committees will be drafted by a member of the corporate communications team, in consultation with the Research Officer for the review and approved by Select Committee Chairman, in consultation with the Overview, Scrutiny and Localism Manager.

- Press releases will be fair and representative of the views of the Select Committee. They may include the views expressed in minority reports if those views differ from the main report.

- The media are invited to attend all formal meetings of Select Committee unless matters of an exempt nature are to be discussed.

- When the report of the Select Committee is ready to go into the public domain a member of the corporate communications team, in consultation with the Research Officer to the Select Committee drafts a press release. Where possible the press release should include input from a third party who has been involved with the review. The Press release should be approved by the Select Committee Chairman (with the nominated official spokesman, where appropriate) in consultation with the Overview, Scrutiny and Localism Manager. An embargoed copy of the press release should be sent out with an electronic copy of the report, to the media a day before the public domain with an embargo on it. There may or may not be a press conference but the Chairman, relevant members make sure they are available for interviews.

- Corporate Communications officers are permitted to refuse to prepare press releases, deal with media enquiries or arrange media interviews in the following cases:

  (i) If the press release or enquiry is political in any way.
  (ii) If the information in the press release is deemed libellous or malicious

- Corporate Communications officers will not organise interviews between media and individual members of the Select Committee unless there is explicit agreement by the Select Committee Chairman.

- Press releases will not be issued as a matter of course after Select Committee meetings simply to record the proceedings. Post-meeting publicity will, however, be given where there is good reasons for doing so e.g. to promote opportunities for public consultation.

This page is intentionally left blank

By: Graham Gibbens, Cabinet Member Adult Social Services
Oliver Mills, Managing Director Kent Adult Social Services

To: Adult Social Services Policy Overview Committee – 22 September 2009

Subject: **ADULT SOCIAL SERVICES BUDGET MONITORING 2009/10 – FIRST QUARTERLY REPORT**

Classification: Unrestricted

Summary: A report on the July 2009 Full Monitoring report for Kent Adult Social Services.

Introduction

1. (1) This is the second report for 2009-10 to this Committee on the forecast outturn against budget for the Adult Social Services Department.

Background

2. (1) Policy Overview Committees consider the draft Medium Term Financial Plan at their November and January meetings. To enable a more informed discussion, three reports will be presented to the Committee on a regular basis:

a) **Budget Monitoring reports**
A detailed quarterly budget monitoring report is presented to Cabinet, usually in September, December and March, and a draft final outturn report in June. A report for each directorate is annexed to the summary report, and the annex for the Adult Social Services Directorate will be presented to this Committee at the meetings following those Cabinet meetings. This will help inform this POC about current trends, pressures and management actions in advance of the next year's budget setting

b) **Performance data**
This will be reported at least half-yearly to this Committee.

c) **Outturn report**
Effectively an amalgam of the above two, the outturn report will summarise both the financial and performance information for the whole of the preceding year

(2) Informed by these reports, the POCs will be in a stronger position to question and comment on the future budget and medium term proposals, as they will be asked to do at the November and January meetings.

(3) If required a special Budget IMG can be arranged as happened last year to discuss the future Budget and MTP proposals in more detail.

July 2009 Full Monitoring report

3. (1) The July 2009 Full Monitoring report for Adult Social Services as presented to Cabinet on 14 September is attached at Appendix 1 and this indicates an overall revenue pressure of £0.496m. Appropriate 'Guidelines for Good Management Practice' will be implemented to ensure that the Directorate achieves a balanced position by the end of the year.

(2) The main areas to note within the latest position are:

- All savings identified within the Medium Term Plan will be achieved.
- The Directorate has reviewed all cash limits and affordable levels of activity in light of the 2008/09 out-turn and any changing trends in activity that have become apparent since the budget was set. A number of requests for virement and other changes to cash limits are included as part of the report submitted to Cabinet.
- Older People is forecasting a net underspend of £1.402m. Within this is a net underspend of £0.692m against residential care which assumes a reduction in the number of clients based on trends. The number of clients in permanent residential care has reduced from 2,832 in March to 2,817 in April and stood at 2,733 in June, although the number of clients with dementia is increasing. Nursing care is forecasting a small net pressure of £0.078m as the number of clients with dementia is expected to increase even though the number of Older People who are frail is expected to remain fairly stable. The number of clients in permanent nursing care has increased marginally from 1,332 in March to 1,340 in June. Domiciliary care remains the most volatile and difficult line to forecast with great accuracy. This line is reporting a net underspend of £0.823m as the number of clients remains below the affordable level, with the June figure of 6,422 showing a drop of 68 clients since March.

- Services for People with a Learning Difficulty is showing an overall pressure of £1.558m as both demographic and price placement pressures continue. These primarily relate to young adults with very complex needs transferring from Children's Services, clients with ageing parents cared for at home but requiring more support, and the numbers of people placed by other authorities but being classed as 'ordinarily resident' (deemed as living in the county rather than in a residential placement) and therefore our responsibility. Although the number of residential placements has decreased from 640 in March to 632 in June this is still well above the affordable level and this line is showing a net pressure of £1.569m. The forecast also assumes that, where appropriate, clients transfer to supported accommodation as the Directorate tries to support clients within the community. As with residential the activity is in excess of the affordable level with the number of clients increasing from 233 in March to 276 in June. The overall forecast pressure has also been reduced by £600k following release of the contingency held by the Managing Director.

- Services for People with a Physical Disability have similar pressures to Services for People with a Learning Difficulty and as a result the overall position is a pressure of £0.290m. Although the number of residential placements has reduced from 222 in March to 217 in April and again to 213 in June this is still well above the affordable level and this line is showing a net pressure of £0.652m. The overall forecast pressure has also been reduced by £200k following release of the contingency held by the Managing Director

- The position for Mental Health is a net pressure of £0.249m. Within this is a gross pressure of £0.585m against residential care as the number of clients is expected to remain above the level afforded in the budget. It should be noted that the budgets were realigned in 2008-09 to reflect the changed priorities in the Directorate to keep clients, wherever possible, within a community based setting such as supported accommodation or via direct payments, rather than residential care, however this change has not happened as quickly as anticipated. This has resulted in an underspend of £0.357m against direct payments. The forecast for residential care also assumes an under-recovery in income of £0.276m as there is an increasing proportion of clients who fall under Section 117 meaning that they do not contribute to the cost of their care.

(3) The Capital budget is showing a real variance of £0.025m after requesting for £4.962m to be re-phased. Of this £2.600 relates to Dartford Town Centre and £1.530m to the Broadmeadow extension. Dartford Town Centre is largely dependent upon a retail and residential development, the start of which has been delayed by the developer due to the present economic climate. The earliest anticipated start date is now in next financial year. Submission of planning permission for the Broadmeadow extension will now take place in September meaning that completion of the project will be four months later than originally thought, which will be in December 2010.

(4) The outstanding debt that was due for payment as at July was £13.9m of which £12.0m related to client debt with £1.9m of sundry debt. This compared with total due debt as at June of £12.6m of which £11.4m was client debt and £1.2m of sundry debt.

Recommendations

4. (1) Members of the Policy Overview Committee are asked to note the projected outturn figures for the Directorate as at the September Cabinet report.

Michelle Goldsmith
Directorate Finance Manager
Tel: 01622 221770
VPN: 7000 1770

This page is intentionally left blank

KENT ADULT SOCIAL SERVICES DIRECTORATE SUMMARY JULY 2009-10 FULL MONITORING REPORT

1. FINANCE

1.1 REVENUE

1.1.1 The cash limits that the Directorate is working to, **and upon which the variances in this report are based**, include adjustments for both formal virement and technical adjustments, the latter being where there is no change in policy. The Directorate would like to request formal virement through this report to reflect adjustments to cash limits required for the following changes required in respect of the allocation of previously unallocated budgets where further information regarding allocations and spending plans has become available since the budget setting process. This primarily relates to how the Directorate allocated demography/growth and savings, and how grant funding was allocated, decisions for which were made following a Special Budget SMT in January and subsequent detailed analysis by Areas. Where necessary allocations have been adjusted in light of the 2008-09 outturn, whereas before they would have been based on forecasts from several months earlier. As a result demography/growth and savings have in some cases been allocated across different headings to those assumed within budget build. Cash limits also need to be adjusted to reflect the changing trends in services over the past couple of years through modernisation of services and the move towards more self directed support. Services are now more likely to be community based, for example in supported accommodation, or through a domiciliary care package, or via a direct payment, rather than residentially based (although there are exceptions where very complex needs remain, e.g. many Older People with Mental Health Needs and clients with severe Learning or Physical Disabilities). The value of these changes is an increase of £3,283k in gross and a £3,283k increase in income.

Cash limits have also been adjusted to reflect a number of technical adjustments to budget, including realignment of gross and income to more accurately reflect current levels of services and the inclusion of a number of 100% grants/contributions (i.e. which fully fund the additional costs) awarded since the budget was set. These include the increase in the HIV/AIDS grant £45k, new grants for 'P Plate' adult social workers to support newly qualified staff £22k and £150k for Minor repairs and adaptations 'handyperson' grant, and reflects the receipts in advance carried forward from 2008-09 for Learning Disability Campus Reprovision Grant £174k and Social Care Reform Grant £761k. It was previously acknowledged that some of the income budgets were not correctly aligned to where the gross budget was held. This should have been rectified in budget build but regrettably was not hence a number of adjustments are now required. The value of these changes is a £5,133k increase in gross and a £5,133k increase in income. Of this approximately £3.5m relates to additional funding from Health, and a further £1m relates to the correct accounting treatment for recharges.

These adjustments have resulted in an overall increase in the gross expenditure budget of £9,568k (£3,283k + £45k + £22k + £150k + £174k + £761k + £5,133k) and an increase in the income budget of an equal amount, giving a net nil effect.

In addition there has been an increase of £553k in the gross budget in relation to approved roll-forwards from 2008-09.

Therefore the overall movement in cash limits shown in table 1a below is an increase of £10,121k in gross expenditure (£9,568k + £553k) and an increase in income of £9,568k.

Table 1a shows:

- the published budget,
- the proposed budget following adjustments for both formal virement and technical adjustments, together with roll forward from 2008-09 as approved by Cabinet in July,
- the total value of the adjustments applied to each service line.

Cabinet is asked to approve these revised cash limits:

The changes to cash limits referred to above have also impacted on the 2009-10 affordable levels of activity and these have been updated within section 2 of this annex to reflect the revised cash limits outlined in Tables 1a and 1b.

1.1.2.1 **Table 1a: Movement in cash limits since Published Budget**

Budget Book Heading	Published Budget			Current Cash Limit			Movement in Cash Limit		
	G	I	N	G	I	N	G	I	N
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Adult Services portfolio									
Older People:									
- Residential Care	84,184	-29,330	54,854	88,635	-31,724	56,911	4,451	-2,394	2,057
- Nursing Care	43,004	-19,176	23,828	43,647	-19,507	24,140	643	-331	312
- Domiciliary Care	48,539	-9,807	38,732	47,233	-10,317	36,916	-1,306	-510	-1,816
- Direct Payments	4,372	-455	3,917	4,638	-436	4,202	266	19	285
- Other Services	20,006	-3,027	16,979	21,607	-4,645	16,962	1,601	-1,618	-17
Total Older People	200,105	-61,795	138,310	205,760	-66,629	139,131	5,655	-4,834	821
People with a Learning Difficulty:									
- Residential Care	66,316	-10,975	55,341	64,909	-12,119	52,790	-1,407	-1,144	-2,551
- Domiciliary Care	7,356	-850	6,506	6,704	-650	6,054	-652	200	-452
- Direct Payments	6,012	-122	5,890	5,465	-84	5,381	-547	38	-509
- Supported Accommodation	7,547	-1,044	6,503	9,582	-1,151	8,431	2,035	-107	1,928
- Other Services	19,493	-1,356	18,137	20,326	-1,924	18,402	833	-568	265
Total People with a LD	106,724	-14,347	92,377	106,986	-15,928	91,058	262	-1,581	-1,319
People with a Physical Disability									
- Residential Care	12,501	-2,022	10,479	12,254	-1,987	10,267	-247	35	-212
- Domiciliary Care	7,568	-459	7,109	7,317	-439	6,878	-251	20	-231
- Direct Payments	6,401	-280	6,121	6,697	-250	6,447	296	30	326
- Supported Accommodation	418	-13	405	394	-8	386	-24	5	-19
- Other Services	5,644	-741	4,903	6,530	-1,237	5,293	886	-496	390
Total People with a PD	32,532	-3,515	29,017	33,192	-3,921	29,271	660	-406	254
All Adults Assessment & Related	36,084	-1,670	34,414	37,205	-1,917	35,288	1,121	-247	874
Mental Health Service									
- Residential Care	6,610	-992	5,618	6,456	-974	5,482	-154	18	-136
- Domiciliary Care	903		903	627		627	-276	0	-276
- Direct Payments	386		386	602		602	216	0	216
- Supported Accommodation	355	-63	292	435	0	435	80	63	143
- Assessment & Related	10,060	-876	9,184	9,982	-876	9,106	-78	0	-78
- Other Services	6,545	-904	5,641	6,736	-904	5,832	191	0	191
Total Mental Health Service	24,859	-2,835	22,024	24,838	-2,754	22,084	-21	81	60
Supporting People	32,882		32,882	33,033	-150	32,883	151	-150	1
Gypsy & Traveller Unit	630	-289	341	630	-289	341	0	0	0
People with no recourse to Public Funds	100		100	100		100	0	0	0
Strategic Management	1,303		1,303	1,339		1,339	36	0	36
Strategic Business Support	21,844	-519	21,325	24,219	-1,971	22,248	2,375	-1,452	923
Support Services purchased from CED	7,462		7,462	7,344		7,344	-118	0	-118
Specific Grants		-38,637	-38,637		-39,616	-39,616		-979	-979
Adult Services controllable	**464,525**	**-123,607**	**340,918**	**474,646**	**-133,175**	**341,471**	**10,121**	**-9,568**	**553**

1.1.2.2 **Table 1b** below details the revenue position by Service Unit against the revised cash limits shown in table 1a:

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Adult Services portfolio							
Older People:							
- Residential Care	88,635	-31,724	56,911	-616	-76	-692	Reducing clients but price pressures due to complexity
- Nursing Care	43,647	-19,507	24,140	303	-225	78	Demographic and placement pressures offset with additional income
- Domiciliary Care	47,233	-10,317	36,916	-926	103	-823	Reducing clients but price pressures due to complexity
- Direct Payments	4,638	-436	4,202	-67	-25	-92	
- Other Services	21,607	-4,915	16,692	124	-17	107	Small gross variances against a number of lines
Total Older People	205,760	-66,899	138,861	-1,182	-240	-1,422	
People with a Learning Difficulty:							
- Residential Care	64,909	-12,119	52,790	1,704	-135	1,569	Demographic and placement pressures
- Domiciliary Care	6,704	-650	6,054	97	-71	26	
- Direct Payments	5,465	-84	5,381	62	-14	48	
- Supported Accommodation	9,582	-1,151	8,431	643	-215	428	Demographic and placement pressures
- Other Services	19,908	-1,506	18,402	-488	-25	-513	Release of Managing Director's Contingency to offset overall pressure
Total People with a LD	106,568	-15,510	91,058	2,018	-460	1,558	
People with a Physical Disability							
- Residential Care	12,254	-1,987	10,267	780	-128	652	Demographic and placement pressures
- Domiciliary Care	7,318	-439	6,879	95	-9	86	
- Direct Payments	6,697	-250	6,447	-34	9	-25	
- Supported Accommodation	394	-8	386	-99	5	-94	
- Other Services	6,033	-692	5,341	-342	13	-329	Release of Managing Director's Contingency to offset overall pressure
Total People with a PD	32,696	-3,376	29,320	400	-110	290	
All Adults Assessment & Related	37,155	-1,918	35,237	63	-95	-32	
Mental Health Service			0			0	
- Residential Care	6,456	-974	5,482	585	276	861	Forecast activity in excess of affordable level; increased proportion of S117 clients
- Domiciliary Care	540		540	27	0	27	
- Direct Payments	602		602	-357	0	-357	Less than expected activity
- Supported Accommodation	585	-63	522	27	-51	-24	
- Assessment & Related	9,982	-876	9,106	-90	-24	-114	
- Other Services	6,736	-904	5,832	-96	-48	-144	
Total Mental Health Service	24,901	-2,817	22,084	96	153	249	

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Supporting People	32,883	0	32,883	0	0	0	
Gypsy & Traveller Unit	630	-289	341	0	0	0	
People with no recourse to Public Funds	100		100	0	0	0	
Strategic Management	1,339		1,339	8	3	11	
Strategic Business Support	23,486	-1,238	22,248	-64	-94	-158	
Support Services purchased from CED	7,344		7,344	0	0	0	
Specific Grants		-39,616	-39,616	0	0	0	
Total Adult Services controllabl	**472,862**	**-131,663**	**341,199**	**1,339**	**-843**	**496**	
Assumed Management Action				**-496**		**-496**	
Forecast after Mgmt Action				**843**	**-843**	**0**	

1.1.3 **Major Reasons for Variance**:

Table 2, at the end of this section, details all forecast revenue variances over £100k. Each of these variances is explained further below:

1.1.3.1 **Older People:**

The overall net position is an underspend of £1,422k. Although there are underlying pressures remaining within in-house residential care, nursing care, and Older People with Mental Health Needs, the Directorate is reporting an underspend against domiciliary care and a continuing reduction in the number of Older People who do not have a Mental Health Need requiring independent permanent residential care.

a. Residential Care

This line is reporting a gross underspend of £616k as the number of clients in permanent care continues to reduce, with the June figure of 2,733 down from 2,832 in March. The forecast position is 155,824 weeks of care against an affordable level of 157,572, which is a difference of 1,748 weeks. Using the forecast unit cost of £385.47, this reduced level of activity generates an under spend of £674k. In addition the forecast unit cost is £1.95 higher than the affordable which results in a pressure of £307k. This pressure reflects the increasing number of clients with dementia as placements are more expensive, and this trend can clearly be seen in table 2.1.2. Although the reduction in activity also means a reduced level of income of £270k, the actual income per week is £154.45 against an expected level of £150.13. This gives an over-recovery in income of £681k.

The forecast number of client weeks of service provided to Preserved Rights clients is 1,195 lower than the affordable level because of increased attrition which is over and above that assumed in the budget. This reduced activity gives an underspend of £479k with a further reduction of £19k because the unit cost is slightly below the affordable level. The reduction in activity also results in an under-recovery in income of £237k.

In house residential provision is showing a pressure of £275k on staffing because of the continuing need to cover sickness and absence with agency staff in order to meet care standards.

b. Nursing Care

There is a pressure of £303k on gross expenditure and client numbers have increased from 1,332 in March to 1,340 in June. The forecast is assuming 324 weeks more than budget at a cost of £152k. The unit cost is also forecast to be higher than budget, £470.37 instead of £468.95, which increases the pressure by £106k. The additional activity has resulted in increased income of £49k. Also the actual income per week is £151.53 against an expected level of £148.81. This gives an over-recovery in income of £204k.

Preserved Rights is showing a small pressure of £45k against gross and a small under-recovery in income of £13k.

There is currently an underspend of £25k against Registered Nursing Care Contributions with an identical under-recovery of income and is based on the latest estimates of client activity.

c. Domiciliary Care

This service remains the most volatile and difficult to forecast and currently this line is forecasting an underspend against gross of £926k. The numbers of people receiving a domiciliary care package from the independent sector has decreased over the last year, but stabilised in the first quarter this year and the continuing trend remains uncertain. However the budget still allows for significantly more hours than is being delivered and the current forecast under-delivery is over 122,000 hours, giving a saving of £1,893k. The forecast unit cost is also £0.415 per hour more expensive than affordable generating an additional cost of £1,057k. This will relate to the fact that people who do receive domiciliary care, in its traditional sense, are more likely to have higher needs and require more intense packages.

There is also a small underspend of £90k relating to the in-house domiciliary service.

The reduced level of activity has meant a corresponding under-recovery in income of £103k.

d. Other Services

A small pressure of £124k is forecast against gross expenditure which relates to a number of small variances, both over and under, against the remaining services, including meals, payments to voluntary organisations, occupational therapy and day-care.

1.1.3.2 **People with a Learning Difficulty:**

Overall the position for this client group is a net pressure of £1,558k. Services for this client group remain under extreme pressure, particularly within residential care and supported accommodation, as a result of both demographic and placement price pressures.

The impact of young adults transferring from Children's Services, many of whom have very complex needs and require a much higher level of support, continues to be felt. Alongside these so-called "transitional" placements are the increasing number of older learning disabled clients who are cared for at home by ageing parents who will begin to require more support. There are also more cases of clients becoming "ordinarily resident" in Kent. A client would become "ordinarily resident" when placed by another local authority in Kent and following de-registration of the home, the individual moves into supported accommodation.

a. Residential Care

The overall forecast for residential care, including preserved rights clients, is an overspend on gross of £1,704k partially offset by over recovery of income of £135k, giving a net pressure of £1,569k. Details of the individual pressures and savings contributing to this position are provided below.

Although the number of clients has reduced from 640 in March to 632 in June, the forecast assumes 652 weeks more than is affordable at a cost of £738k. This position includes those known young people who are in the "transition" process and will be coming to adult social services before the end of the year. The actual unit cost is £1,131.43 which is £21.28 higher than the affordable which adds £695k to the forecast. The additional client weeks adds £117k of income with a further £41k of income resulting from slightly more income per week than expected.

As with Older People, in house residential provision is showing a pressure of £183k on staffing because of the need to cover sickness and absence with agency staff to meet national care standards.

There has also been a contribution of £170k to a provision for a potential future liability.

b. Supported Accommodation

The current position is a net pressure of £428k with the number of clients having increased from 233 in March to 276 in June, although it is not expected that this large increase in clients over the first three months will be repeated throughout the rest of the year. The forecast for activity is 128

weeks over the affordable level which generates a pressure of £74k. The unit cost of £577.33 is also £33.02 per week higher than is affordable and this increases the pressure by £554k. The additional activity and a higher than expected average contribution per week generates an additional £190k of income.

c. Other Services
This line is showing a gross underspend of £488k following the release of £600k of the Contingency held by the Managing Director to offset the overall pressure within the Directorate. There are also small variances, both over and under, against the remaining services, including payments to voluntary organisations, day-care and supported employment.

1.1.3.3 **People with a Physical Disability:**

Overall the position for this client group is a net pressure of £290k. Services for this client group remain under pressure as a result of both demographic and placement price pressures. As a result there continues to be a significant forecast pressure against residential care.

a. Residential Care
The overall forecast for residential care, including preserved rights clients, is a pressure on gross of £780k partially offset by over recovery of income of £128k, giving a net pressure of £652k.

Although the number of clients has reduced from 222 in March to 213 in June, the forecast assumes 552 weeks more than is affordable at a cost of £495k. The actual unit cost is £896.33 which is £20.44 higher than the affordable which adds £241k to the forecast. The additional client weeks adds £95k of income to the position.

b. Other Services
This line is showing a gross underspend of £342k following the release of £200k of the Contingency held by the Managing Director to offset the overall pressure within the Directorate. There are also small variances, both over and under, against the remaining services, including payments to voluntary organisations, day-care and occupational therapy.

1.1.3.4 **Mental Health:**

Overall the position for this client group is a net pressure of £249k.

a. Residential Care
The overall forecast for residential care, including preserved rights clients, is a pressure on gross of £585k. The affordable level was reduced as a result of the decision in both 2008-09 and 2009-10 to realign budgets to reflect the changed priorities in the Directorate to keep clients, wherever possible, within a community based setting such as supported accommodation or via direct payments, rather than residential care, however this change has not happened as quickly as anticipated. The result is a forecast which is 1,153 weeks more than is affordable at a cost of £622k. The actual unit cost is £539.70 which is £7.80 higher than the affordable which adds £68k to the forecast. The forecast also assumes a significant under-recovery in income as an increasing proportion of clients fall under Section 117 legislation meaning that they do not contribute towards the cost of their care. This has added £276k to the pressure.

b. Direct Payments
As referred to above the affordable level has been increased in both 2008-09 and 2009-10 to reflect the changed priorities in the Directorate to keep clients, wherever possible, within a community based setting such as supported accommodation or via direct payments, rather than residential care, however this change has not happened as quickly as anticipated. The result is a gross forecast which is significantly underspending against budget by £357k.

Table 2: REVENUE VARIANCES OVER £100K IN SIZE ORDER
(shading denotes that a pressure/saving has an offsetting entry which is directly related)

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
KASS	Older People Domiciliary gross - pressure relating to change in unit cost in independent sector hours	+1,057	KASS	Older People Domiciliary gross - activity lower than anticipated	-1,893
KASS	LD Residential gross - activity in excess of affordable level in independent sector placements	+738	KASS	Older People Residential income resulting from higher unit cost	-681
KASS	LD Residential gross - pressure relating to change in unit cost in independent sector care	+695	KASS	Older People Residential gross - activity below affordable level	-674
KASS	MH Residential gross - transfer of clients to community based care/direct payments not yet happened	+622	KASS	LD Other Services gross - release of the balance of the Managing Director's contingency	-600
KASS	LD Supported Accommodation gross - pressure relating to change in unit cost	+554	KASS	Older People Residential gross - Preserved Rights increased attrition	-479
KASS	PD Residential gross - activity in excess of affordable level in independent sector placements	+495	KASS	MH Direct Payments gross - increase in expected activity in community based care/direct payments not yet happened	-357
KASS	Older People Residential gross - change in unit cost in independent sector placements	+307	KASS	Older People Nursing income resulting from higher unit cost	-204
KASS	MH Residential income - reduced income due to increasing proportion of clients who are S117, and therefore do not contribute towards costs	+276	KASS	PD Other Services gross - release of the balance of the Managing Director's contingency	-200
KASS	Older People Residential gross - in house provision staffing	+275	KASS	LD Support Accomm income - addit activity/higher contribution	-190
KASS	Older People Residential income - under-recovery of income due to lower activity	+270	KASS	LD Residential income - additional income resulting from additional activity	-117
KASS	PD Residential gross - change in unit cost of independent sector placements	+241			
KASS	Older People Residential income - Preserved rights reduced income due to higher attrition	+237			
KASS	LD Residential gross - in house provision staffing	+183			
KASS	LD Residential gross - contribution to provision for potential future liability	+170			
KASS	Older People Nursing gross - activity in excess of affordable level in independent sector placements	+152			
KASS	Older People Nursing gross - change in unit cost in independent sector placements	+106			
KASS	Older People Domiciliary income - reduced due to lower activity	+103			
		+6,481			-5,395

1.1.4 **Actions required to achieve this position**:

The forecast pressure of £496k assumes that the savings identified within the MTP will be achieved and the Directorate remains confident that all savings will be achieved.

1.1.5 **Implications for MTP**:

The MTP assumes a breakeven position for 2009-10.

1.1.6 **Details of re-phasing of revenue projects**:

No revenue projects have been identified for re-phasing.

1.1.7 **Details of proposals for residual variance**:

The KASS Directorate is wholly committed to delivering a balanced outturn position by the end of the financial year. KASS has 'Guidelines for Good Management Practice' in place across all teams in order to help us manage demand on an equitable basis consistent with policy and legislation. Robust monitoring arrangements are in place on a monthly basis to ensure that forecasts and expenditure are closely monitored and where necessary challenged. Through these arrangements the Directorate expects to balance the £496k pressure by the end of the year.

1.2 CAPITAL

1.2.1 All changes to cash limits are in accordance with the virement rules contained within the constitution and have received the appropriate approval via the Leader, or relevant delegated authority.

The capital cash limits have been adjusted since last reported to Cabinet on 13th July 2009, as detailed in section 4.1.

1.2.1 **Table 3** below provides a portfolio overview of the latest capital monitoring position excluding PFI projects.

	Prev Yrs Exp £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	Future Yrs £000s	TOTAL £000s
Kent Adult Social Services portfolio						
Budget	18,023	11,267	17,130	13,770	12,651	72,841
Additions:						
- roll forward	-1,386	1,387	-1			0
- Outturn and pre-outturn changes	-13,770					-13,770
- Flexible & Mobile Engagement		-1,161				-1,161
- Edenbridge Community Centre			26			26
Revised Budget	2,867	11,493	17,155	13,770	12,651	57,936
Variance		-4,987	2,677	2,310		0
split:						
- real variance		-25	+25			0
- re-phasing		-4,962	+2,652	+2,310		0
Real Variance	**0**	**-25**	**+25**	**0**	**0**	**0**
Re-phasing	**0**	**-4,962**	**+2,652**	**+2,310**	**0**	**0**

1.2.3 **Main Reasons for Variance**

Table 4 below, details all forecast capital variances over £250k in 2009-10 and identifies these between projects which are:

- part of our year on year rolling programmes e.g. maintenance and modernisation;
- projects which have received approval to spend and are underway;
- projects which are only at the approval to plan stage and
- projects at preliminary stage.

The variances are also identified as being either a real variance i.e. real under or overspending which has resourcing implications, or a phasing issue i.e. simply down to a difference in timing compared to the budget assumption.

Each of the variances in excess of £1m which is due to phasing of the project, excluding those projects identified as only being at the preliminary stage, is explained further in section 1.2.4 below.

All real variances are explained in section 1.2.5, together with the resourcing implications.

Table 4: CAPITAL VARIANCES OVER £250K IN SIZE ORDER

			Project Status			
portfolio	Project	real/ phasing	Rolling Programme	Approval to Spend	Approval to Plan	Preliminary Stage
			£'000s	£'000s	£'000s	£'000s
Overspends/Projects ahead of schedule						
KASS						
			+0	**+0**	**+0**	**+0**
Underspends/Projects behind schedule						
KASS	Dartford Town Centre	Phasing			-2,600	
KASS	Broadmeadow Extension	Phasing		-1,530		
KASS	FAME	Phasing		-480		
			-0	**-2,010**	**-2,600**	**-0**
			+0	**+2,010**	**+2,600**	**+0**

1.2.4 **Projects re-phasing by over £1m**:

1.2.4.1 **Dartford Town Centre; -£2.6 million**

The Dartford Town Centre Project is a new Health and Social Care Centre aiming to relocate and modernise a number of existing day care services into a new building incorporating voluntary services, independent living flats, social enterprise and potentially health care services. The project is largely dependent upon a retail and residential development.

It has rephased by £2.6m representing 48% of the scheme's budget. It has been delayed in starting, as due to the present economic climate, the developer has delayed submitting the planning application to the Borough Council's Planning Committee. This has had the effect of delaying the possible start date of any build on site, and this in turn has delayed the negotiation process for securing developer contributions and suitable space on the site to construct a Health and Social Care Centre. As a result, indications are that should the planning application be approved in the coming months, the earliest anticipated start date would be into the next financial year, hence the rephasing request.

There are currently no financial implications caused by this delay, the project is funded by Capital Receipts which have already been realised, and developer contributions that have been signed and secured from developments in close proximity to the site. Revised phasing of the scheme is now as follows:

	Prior Years	2009-10	2010-11	2011-12	future years	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
BUDGET & FORECAST						
Budget	125	2,610	2,310	500		5,545
Forecast	125	10	2,600	2,810		5,545
Variance	0	-2,600	+290	+2,310	0	0
FUNDING						
Budget:						
prudential	5		500			505
external		470	1,810			2,280
capital receipts	120	2,140		500		2,760
TOTAL	125	2,610	2,310	500	0	5,545
Forecast:						
prudential	5			500		505
external			470	1,810		2,280
capital receipts	120	10	2,130	500		2,760
TOTAL	125	10	2,600	2,810	0	5,545
Variance	**0**	**-2,600**	**+290**	**+2,310**	**0**	**0**

1.2.4.2 **Broadmeadow Extension; -£1.5 million**

This scheme is the construction of an extension to the Broadmeadow Registered Care Centre, with the objective of developing a more cohesive approach towards service commissioning for people with Dementia and OPMH (over the age of 65) and their carers by ensuring that these are more localised, responsive and flexible.

It has rephased by £1.5 million representing 85% of the total value of the scheme. Whilst the rest of the scheme is on track, submission for planning permission for the extension will now take place in September. This means the completion of the project is anticipated to be 4 months behind schedule; expected in December 2010. During this time, services will be accommodated within existing KASS homes, the impact of which is already included within the revenue forecast. Revised phasing of the scheme is now as follows:

	Prior Years	2009-10	2010-11	2011-12	future years	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
BUDGET & FORECAST						
Budget		1,800				1,800
Forecast		270	1,530			1,800
Variance	0	-1,530	+1,530	0	0	0
FUNDING						
Budget:						
prudential		1,800				1,800
TOTAL	0	1,800	0	0	0	1,800
Forecast:						
prudential		270	1,530			1,800
TOTAL	0	270	1,530	0	0	1,800
Variance	**0**	**-1,530**	**+1,530**	**0**	**0**	**0**

1.2.5 **Projects with real variances, including resourcing implications:**

There is anticipated pressure of £0.025m on the Edenbridge project, this is being offset by an underspend against the Public Access project. Taking this into account, there is zero real variance in the KASS capital programme.

1.2.6 **General Overview of capital programme**:

(a) Risks

The main risk to the Adult Services Capital Programme is the funding from Developer Contributions. There are risks around the timing of the receipts, and the degree to which Developers may try to avoid the payment of contributions.
KASS Capital programme currently includes the following in relation to developer contributions

	2009/10	2010/11	2011/12	Future Years	Total
	£'m	£'m	£'m	£'m	£'m
Budget	0.470	2.336	0.865	0.000	3.671
Forecast	0.000	0.996	2.675	0.000	3.671
Variance	-0.470	-1.340	1.810	0.000	-0.000

(b) Details of action being taken to alleviate risks

In order to reduce the risk, KASS are developing a transparent and effective working relationship with third parties, including District and Borough Councils. The aim of this is to ensure KASS are fully of aware of any changes to the agreements as they arise, and can plan around the changes. As can be seen from the table above, KASS require £3.671m of developer contributions to fund their current commitments; however, KASS have £6.364m of developer contributions agreed.

1.2.7 **PFI projects**

- PFI Housing

1. The £72.489m investment in the PFI Housing project represents investment by a third party. No payment is made by KCC for the new/refurbished assets until the asset are ready for use and this is by way of an annual unitary charge to the revenue budget. The completion of the assets is phased over two years and some are now operational.

	Previous years	2009-10	2010-11	2011-12	TOTAL
	£000s	£000s	£000s	£000s	£000s
Budget	8,892	51,818	11,779	0	72,489
Forecast	8,892	51,818	11,779		72,489
Variance	0	0	0	0	0

(a) **Progress and details of whether costings are still as planned (for the 3rd party)**

Overall costings still as planned.

(b) **Implications for KCC of details reported in (a) ie could an increase in the cost result in a change to the unitary charge ?**

The unitary charge is not subject to indexation as the contractor has agreed to a fixed price for the duration of the contract. Deductions will be made during the contract period if performance falls below the standards agreed or if the facilities are unavailable for use.

During the contract period if one of the partners proposes a change that either results in increased costs or a change in the balance of risk, this must be taken to the Project Board for agreement. Each partner has a vote and any decision resulting in a change to the costs or risks would need unanimous approval.

2. The £44.300m investment in the PFI Excellent Homes for All project also represents investment by a third party. No payment is made by KCC for the new/refurbished assets until the asset are ready for use and this is by way of an annual unitary charge to the revenue budget.

	Previous years	2009-10	2010-11	-23	TOTAL
	£000s	£000s	£000s	£000s	£000s
Budget			22,300	22,000	44,300
Forecast			22,300	22,000	44,300
Variance					

(a) **Progress and details of whether costings are still as planned (for the 3rd party)**

Overall costings still as planned.

(b) **Implications for KCC of details reported in (a) ie could an increase in the cost result in a change to the unitary charge ?**

The unitary charge is not subject to indexation as the contractor has agreed to a fixed price for the duration of the contract. Deductions will be made during the contract period if performance falls below the standards agreed or if the facilities are unavailable for use.

During the contract period if one of the partners proposes a change that either results in increased costs or a change in the balance of risk, this must be taken to the Project Board for agreement. Each partner has a vote and any decision resulting in a change to the costs or risks would need unanimous approval.

1.2.8 Project Re-Phasing

It is proposed that a cash limit change be recommended for the following projects that have rephased by greater than £0.100m to reduce the reporting requirements during the year. Any subsequent re-phasing greater than £0.100m can be requested but the full extent of the rephasing will have to be shown. The possible re-phasing is detailed in the table below.

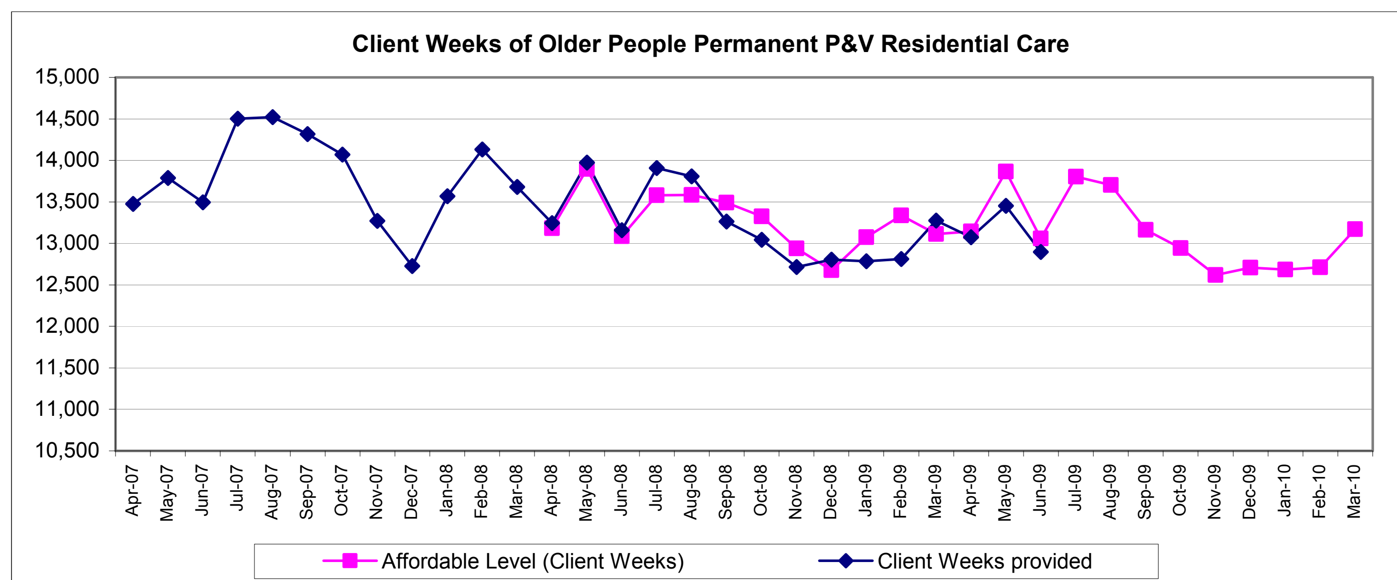
	2009-10	2010-11	2011-12	Future Years	Total
	£k	**£k**	**£k**	**£k**	
Modernisation of Assets					
Amended total cash limits	+1,172	+406	+533	+1,119	+3,230
re-phasing	-143	+143			0
Revised project phasing	**+1,029**	**+549**	**+533**	**+1,119**	**+3,230**
Flexible and Mobile Engagement					
Amended total cash limits	+715				+715
re-phasing	-480	+480			0
Revised project phasing	**+235**	**+480**	**0**	**0**	**+715**
Edenbridge Community & Leisure Centre					
Amended total cash limits	+225	+26			+251
re-phasing	-209	+209			0
Revised project phasing	**+16**	**+235**	**0**	**0**	**+251**
Broadmeadow Extension					
Amended total cash limits	+1,800				+1,800
re-phasing	-1,530	+1,530			0
Revised project phasing	**+270**	**+1,530**	**0**	**0**	**+1,800**
Dartford Town Centre					
Amended total cash limits	+2,610	+2,310	+500		+5,420
re-phasing	-2,600	+290	+2,310		0
Revised project phasing	**+10**	**+2,600**	**+2,810**	**0**	**+5,420**
Total re-phasing >£100k	**-4,962**	**+2,652**	**+2,310**	**0**	**0**
Other re-phased Projects below £100k					
Amended total cash limits					0
re-phasing					0
Revised phasing	**0**	**0**	**0**	**0**	**0**
TOTAL RE-PHASING	**-4,962**	**+2,652**	**+2,310**	**0**	**0**

2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

The changes to cash limits referred to in section 1.1.1 above have impacted on the 2009-10 affordable levels of activity and these have been updated from what was reported to Cabinet within the outturn report in July to reflect the revised cash limits outlined in Tables 1a and 1b.

2.1.1 **Number of client weeks of older people permanent P&V residential care provided compared with affordable level**:

	2007-08		2008-09		2009-10	
	Affordable Level (Client Weeks)	Client Weeks of older people permanent P&V residential care provided	Affordable Level (Client Weeks)	Client Weeks of older people permanent P&V residential care provided	Affordable Level (Client Weeks)	Client Weeks of older people permanent P&V residential care provided
April		13,476	13,181	13,244	13,142	13,076
May		13,789	13,897	13,974	13,867	13,451
June		13,495	13,084	13,160	13,059	12,898
July		14,502	13,581	13,909	13,802	
August		14,520	13,585	13,809	13,703	
September		14,316	13,491	13,264	13,162	
October		14,069	13,326	13,043	12,943	
November		13,273	12,941	12,716	12,618	
December		12,728	12,676	12,805	12,707	
January		13,568	13,073	12,784	12,685	
February		14,131	13,338	12,810	12,712	
March		13,680	13,114	13,275	13,172	
TOTAL	**169,925**	**165,546**	**159,287**	**158,793**	**157,572**	**39,425**

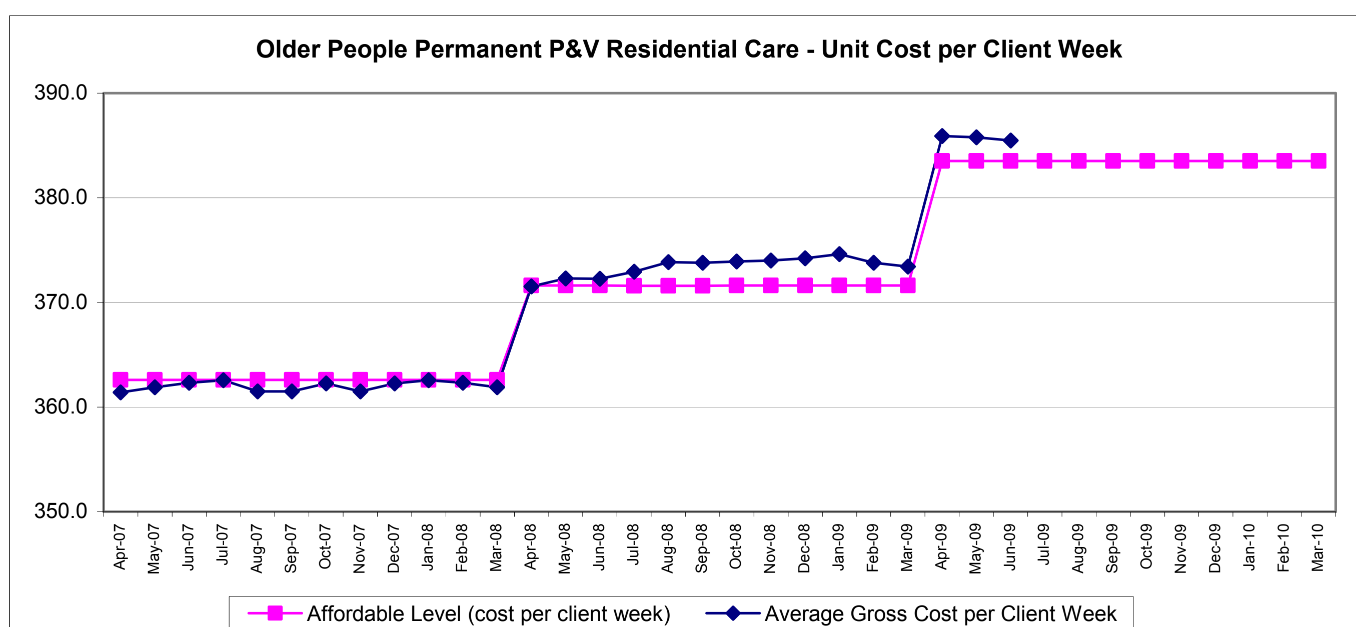


Comments:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people permanent P&V residential care at the end of 2007-08 was 2,917 and at the end of March 2009 it was 2,832. In June, the number was 2,733. This reduction relates to clients without dementia as the number of older people with mental health needs remains stable.
- The forecast position is 155,824 weeks of care against an affordable level of 157,572, which is a difference of 1,748 weeks. Using the actual unit cost of £385.47, this reduced level of activity generates an underspend of £674k as highlighted in section 1.1.3.1.a.
- To the end of June 39,425 weeks of care have been delivered against an affordable level of 40,068, a difference of 643 weeks.

2.1.2 **Average gross cost per client week of older people permanent P&V residential care compared with affordable level**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	362.60	361.41	371.60	371.54	383.52	385.90
May	362.60	361.90	371.60	372.28	383.52	385.78
June	362.60	362.31	371.60	372.27	383.52	385.47
July	362.60	362.56	371.60	372.94	383.52	
August	362.60	361.50	371.60	373.84	383.52	
September	362.60	361.50	371.60	373.78	383.52	
October	362.60	362.27	371.60	373.91	383.52	
November	362.60	361.50	371.60	374.01	383.52	
December	362.60	362.27	371.60	374.22	383.52	
January	362.60	362.56	371.60	374.61	383.52	
February	362.60	362.31	371.60	373.78	383.52	
March	362.60	361.90	371.60	373.42	383.52	

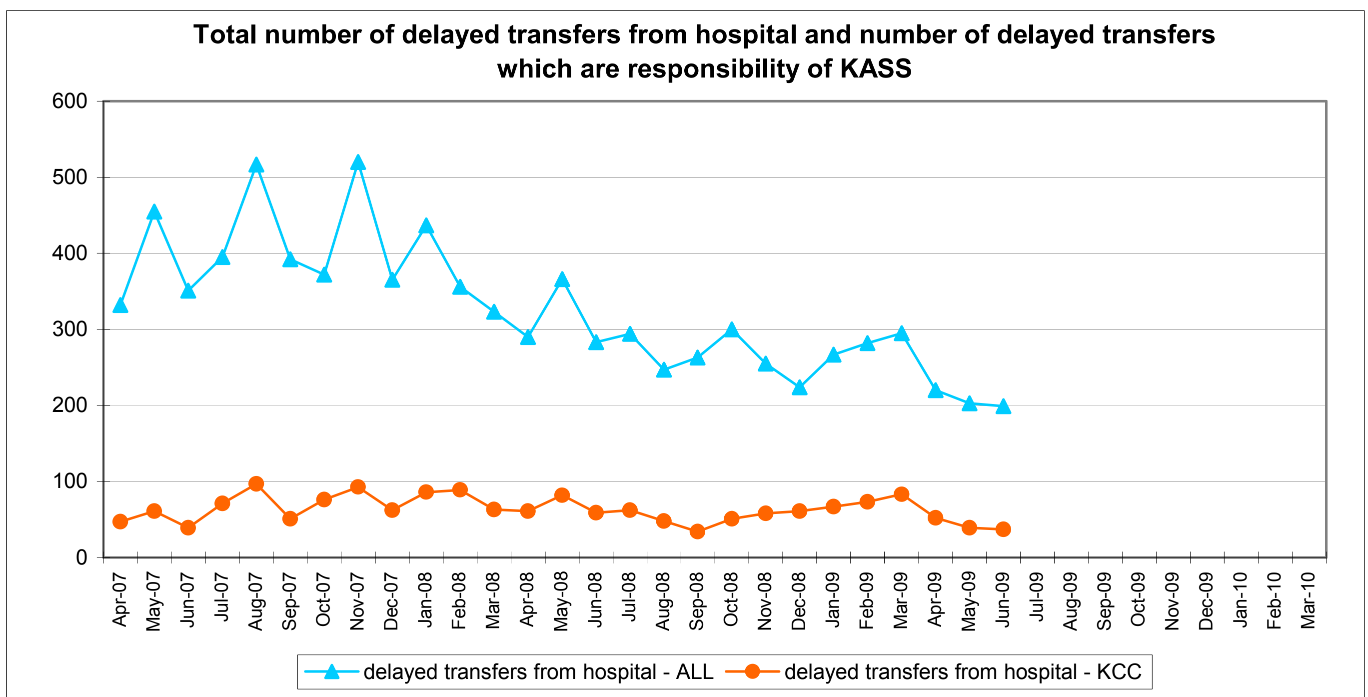


Comments:

- The increase in unit cost over the last year is higher than inflation, but reflects the increasing proportion of clients with dementia.
- The forecast unit cost of £385.47 is higher than the affordable cost of £383.52 and this difference of £1.95 adds £307k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.1.a.

2.1.3 **Total of All Delayed Transfers from hospital compared with those which are KASS responsibility**:

	2007-08		2008-09		2009-10	
	ALL	**KASS responsibility**	**ALL**	**KASS responsibility**	**ALL**	**KASS responsibility**
April	332	47	290	61	220	52
May	455	61	366	82	203	39
June	351	39	283	59	199	37
July	395	71	294	62		
August	517	97	247	48		
September	392	51	263	34		
October	372	76	300	51		
November	520	93	255	58		
December	365	62	224	61		
January	437	86	267	67		
February	356	89	282	73		
March	323	63	295	83		

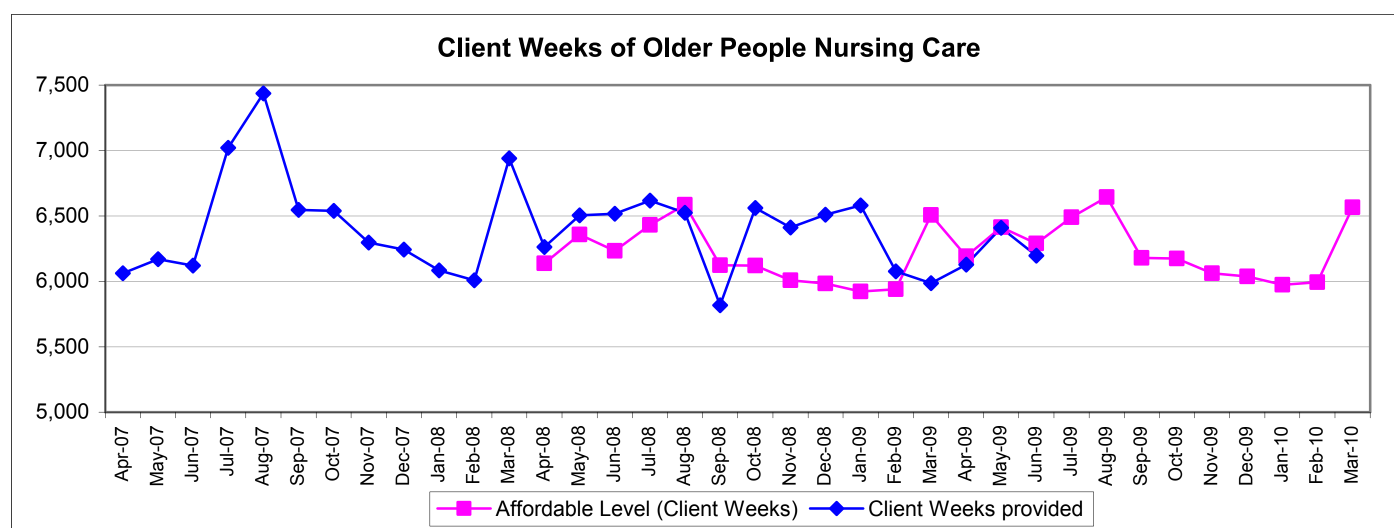


Comments:

- The Delayed Transfers of Care (DTCs) show the numbers of people whose movement from an acute hospital has been delayed. Typically this may be because they are waiting for an assessment to be completed, they are choosing a residential or nursing home placement, or waiting for a vacancy to become available. This figure shows all delays, but those attributable to Adult Social Services, and therefore subject to the reimbursement regime, are a minority. There are many reasons for fluctuations in the number of DTCs which result from the interaction of various different factors within a highly complex system across both Health and Social Care. The average number of delayed transfers per week is on a steadily reducing trend from a peak in the second quarter of 2007/08.

2.2.1 Number of client weeks of older people nursing care provided compared with affordable level:

	2007-08		2008-09		2009-10	
	Affordable Level (Client Weeks)	Client Weeks of older people nursing care provided	Affordable Level (Client Weeks)	Client Weeks of older people nursing care provided	Affordable Level (Client Weeks)	Client Weeks of older people nursing care provided
April		6,062	6,137	6,263	6,191	6,127
May		6,170	6,357	6,505	6,413	6,408
June		6,120	6,233	6,518	6,288	6,195
July		7,020	6,432	6,616	6,489	
August		7,436	6,586	6,525	6,644	
September		6,546	6,124	5,816	6,178	
October		6,538	6,121	6,561	6,175	
November		6,298	6,009	6,412	6,062	
December		6,243	5,984	6,509	6,037	
January		6,083	5,921	6,580	5,973	
February		6,008	5,940	6,077	5,992	
March		6,941	6,507	5,985	6,566	
TOTAL	**74,707**	**77,463**	**74,351**	**76,367**	**75,008**	**18,730**

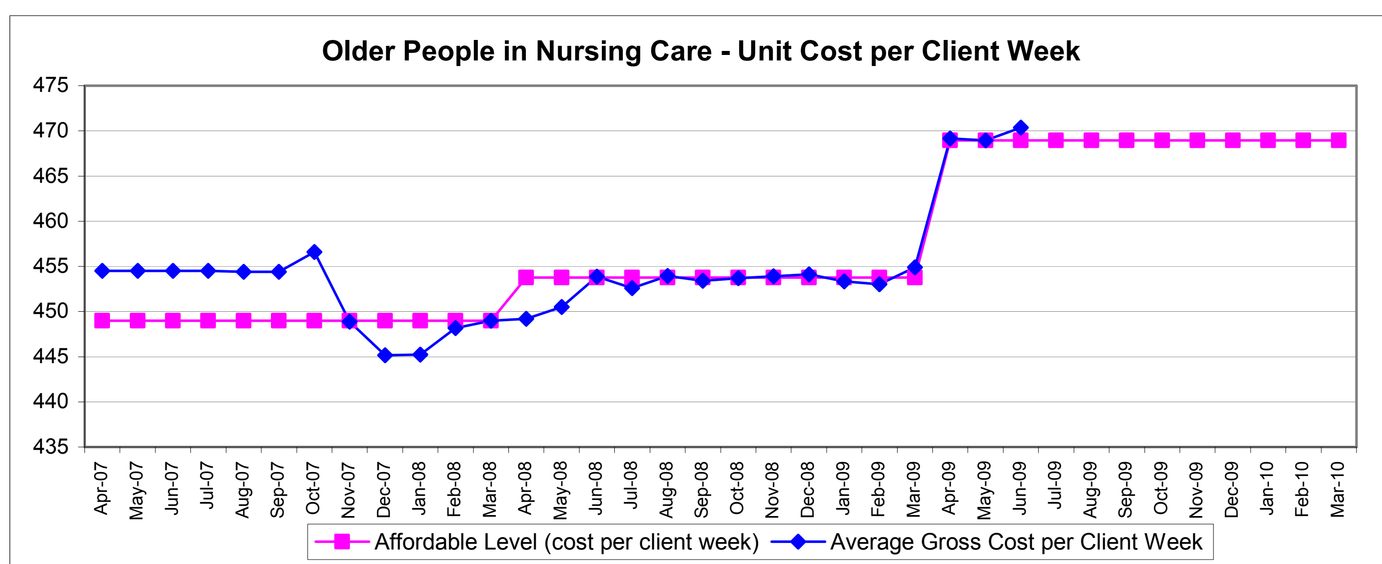


Comment:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people nursing care at the end of 2007-08 was 1,386, at the end of March 2009, it had decreased to 1,332 and in June, it had increased slightly to 1,340. This increase is attributable to people with dementia.
- To the end of June 18,730 weeks of care have been delivered against an affordable level of 18,892, a difference of -162 weeks.
- The forecast position is 75,332 weeks of care against an affordable level of 75,008, a difference of +324 weeks. Using the actual unit cost of £470.37, this additional activity adds £152k to the forecast as highlighted in section 1.1.3.1.b.
- There are always pressures in permanent nursing care which may occur for many reasons. Increasingly, older people are entering nursing care only when other ways of support have been explored. This means that the most dependent are those that enter nursing care and consequently are more likely to have dementia. In addition, there will always be pressures which the directorate face, for example the knock on effect of minimising delayed transfers of care. Demographic changes – increasing numbers of older people with long term illnesses – also means that there is an underlying trend of growing numbers of people needing nursing care.

2.2.2 **Average gross cost per client week of older people nursing care compared with affordable level**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	448.98	454.50	453.77	449.18	468.95	469.15
May	448.98	454.50	453.77	450.49	468.95	468.95
June	448.98	454.50	453.77	453.86	468.95	470.37
July	448.98	454.50	453.77	452.61	468.95	
August	448.98	454.40	453.77	453.93	468.95	
September	448.98	454.40	453.77	453.42	468.95	
October	448.98	456.60	453.77	453.68	468.95	
November	448.98	448.88	453.77	453.92	468.95	
December	448.98	445.16	453.77	454.13	468.95	
January	448.98	445.22	453.77	453.33	468.95	
February	448.98	448.17	453.77	453.02	468.95	
March	448.98	449.00	453.77	454.90	468.95	



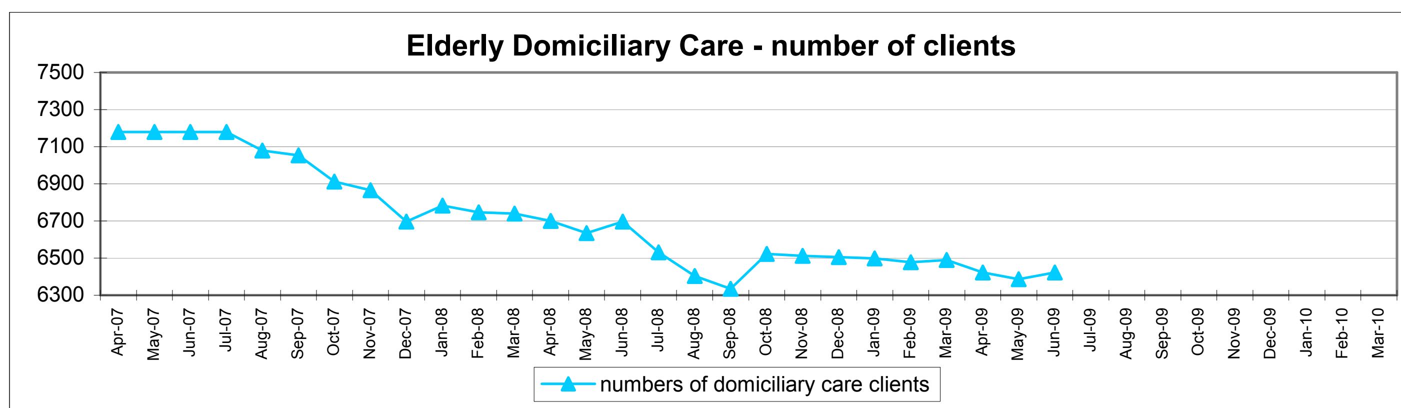
Comments:

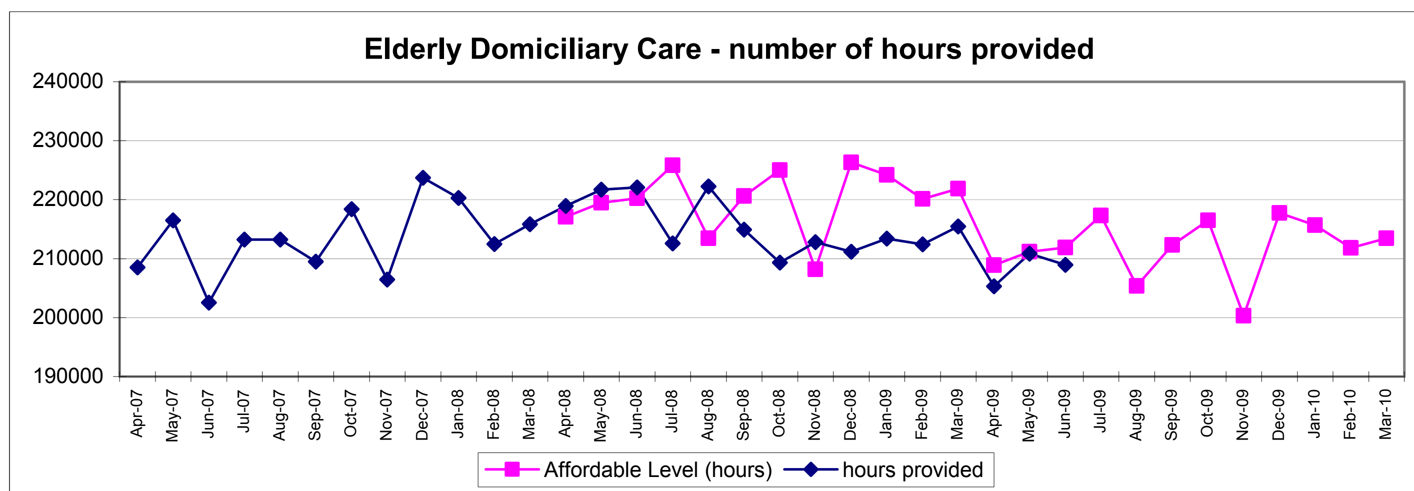
- As with residential care, the unit cost for nursing care will be affected by the increasing proportion of older people with dementia who need more specialist and expensive care

- The forecast unit cost of £470.37 is slightly higher than the affordable cost of £468.95 and this difference of £1.42 adds £106k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.1.b

2.3.1 **Elderly domiciliary care – numbers of clients and hours provided**:

	2007-08			2008-09			2009-10		
	Affordable level (hours)	**hours provided**	**number of clients**	**Affordable level (hours)**	**hours provided**	**number of clients**	**Affordable level (hours)**	**hours provided**	**number of clients**
April		208,524	7,179	217,090	218,929	6,700	208,869	205,312	6,423
May		216,477	7,180	219,480	221,725	6,635	211,169	210,844	6,386
June		202,542	7,180	220,237	222,088	6,696	211,897	208,945	6,422
July		213,246	7,180	225,841	212,610	6,531	217,289		
August		213,246	7,079	213,436	222,273	6,404	205,354		
September		209,504	7,054	220,644	214,904	6,335	212,289		
October		218,397	6,912	225,012	209,336	6,522	216,491		
November		206,465	6,866	208,175	212,778	6,512	200,292		
December		223,696	6,696	226,319	211,189	6,506	217,749		
January		220,313	6,782	224,175	213,424	6,499	215,686		
February		212,499	6,746	220,135	212,395	6,478	211,799		
March		215,865	6,739	221,875	215,488	6,490	213,474		
TOTAL	**2,610,972**	**2,560,774**		**2,642,419**	**2,587,139**		**2,542,358**	**625,101**	





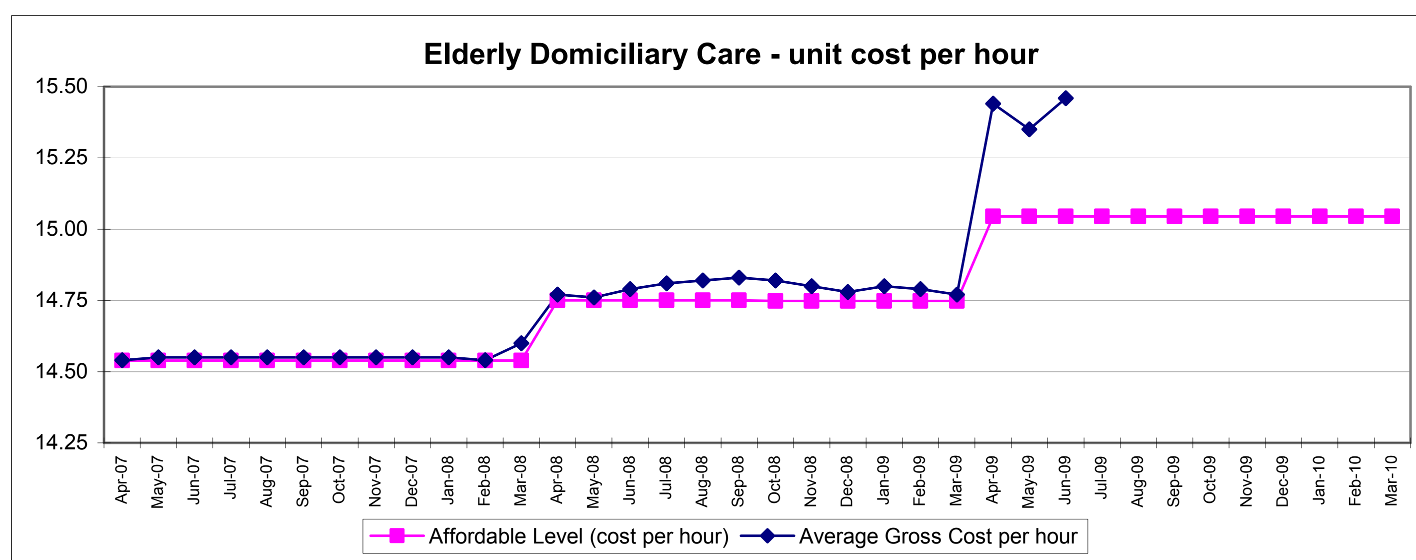
Comment:

- Figures exclude services commissioned from the Kent HomeCare Service.
- The current forecast is 2,419,893 hours of care set against an affordable level of 2,542,358, a difference of 122,465 hours. Using the forecast unit cost of £15.46, this reduction in activity indicates a £1,893k underspend, as highlighted in section 1.1.3.1.c.
- The number of people receiving domiciliary care has decreased over the last year, but stabilised in the first quarter this year. We would not expect the number of domiciliary care clients to be increasing for several reasons. Firstly, the success of preventative services such as intermediate care, rapid response and ongoing service developments with the voluntary sector and other organisations mean that we continue to prevent people from needing 'mainstream' domiciliary care. The LAA target focuses on how we can ensure that people are helped back to their own homes successfully with very

minimal support. In the voluntary sector, people can access services, very often involving social inclusion (e.g. luncheon clubs and other social activities), without having to undergo a full care management assessment. Secondly, public health campaigns and social marketing aimed at improving people's health is already starting to result in healthier older people. Increase in the use of Telecare and Telehealth similarly reduces the need for domiciliary care, and it is possible that this trend will continue despite the growth in numbers of older people. Thirdly, in Kent, as well as nationwide, the take up of direct payments by older people, has for the first time, reached similar levels as people with physical disabilities.

2.3.2 **Average gross cost per hour of older people domiciliary care compared with affordable level**:

	2007-08		**2008-09**		**2009-10**	
	Affordable Level (Cost per Hour)	**Average Gross Cost per Hour**	**Affordable Level (Cost per Hour)**	**Average Gross Cost per Hour**	**Affordable Level (Cost per Hour)**	**Average Gross Cost per Hour**
April	14.50	14.54	14.75	14.77	15.045	15.44
May	14.50	14.55	14.75	14.76	15.045	15.35
June	14.50	14.55	14.75	14.79	15.045	15.46
July	14.50	14.55	14.75	14.81	15.045	
August	14.50	14.55	14.75	14.82	15.045	
September	14.50	14.55	14.75	14.83	15.045	
October	14.50	14.55	14.75	14.82	15.045	
November	14.50	14.55	14.75	14.80	15.045	
December	14.50	14.55	14.75	14.78	15.045	
January	14.50	14.55	14.75	14.80	15.045	
February	14.50	14.54	14.75	14.79	15.045	
March	14.50	14.60	14.75	14.77	15.045	



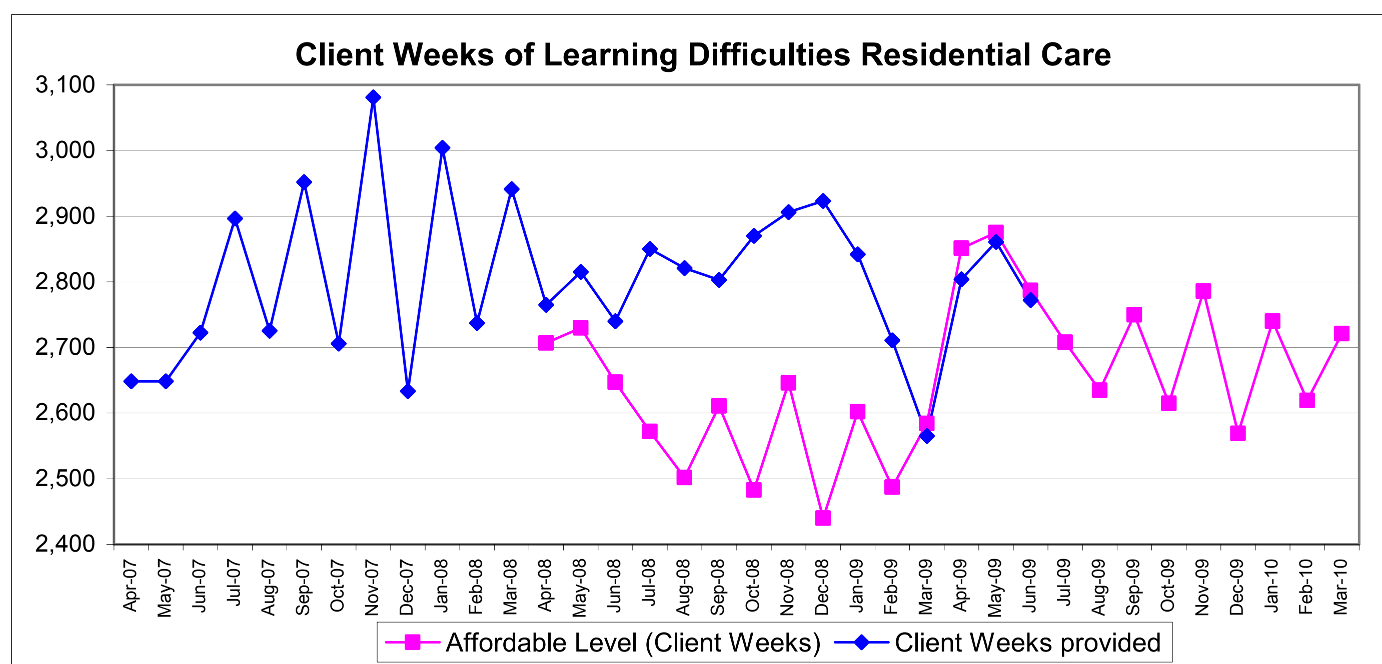
Comments:

- The average unit cost per week is increasing and may reflect the same issues outlined above concerning more intense packages and higher levels of need

- The forecast unit cost of £15.46 is higher than the affordable cost of £15.045 and this difference of £0.415 increases the pressure by £1,057k when multiplied by the affordable hours, as highlighted in section 1.1.3.1.c.

2.4.1 **Number of client weeks of learning difficulties residential care provided compared with affordable level (non preserved rights clients):**

	2007-08		2008-09		2009-10	
	Affordable Level (Client Weeks)	**Client Weeks of LD residential care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD residential care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD residential care provided**
April		2,648	2,707	2,765	2,851	2,804
May		2,648	2,730	2,815	2,875	2,861
June		2,722	2,647	2,740	2,787	2,772
July		2,897	2,572	2,850	2,708	
August		2,725	2,502	2,821	2,635	
September		2,952	2,611	2,803	2,750	
October		2,706	2,483	2,870	2,615	
November		3,081	2,646	2,906	2,786	
December		2,633	2,440	2,923	2,569	
January		3,004	2,602	2,842	2,740	
February		2,737	2,487	2,711	2,619	
March		2,941	2,584	2,565	2,721	
TOTAL	**30,984**	**33,695**	**31,011**	**33,611**	**32,656**	**8,437**



Comments:

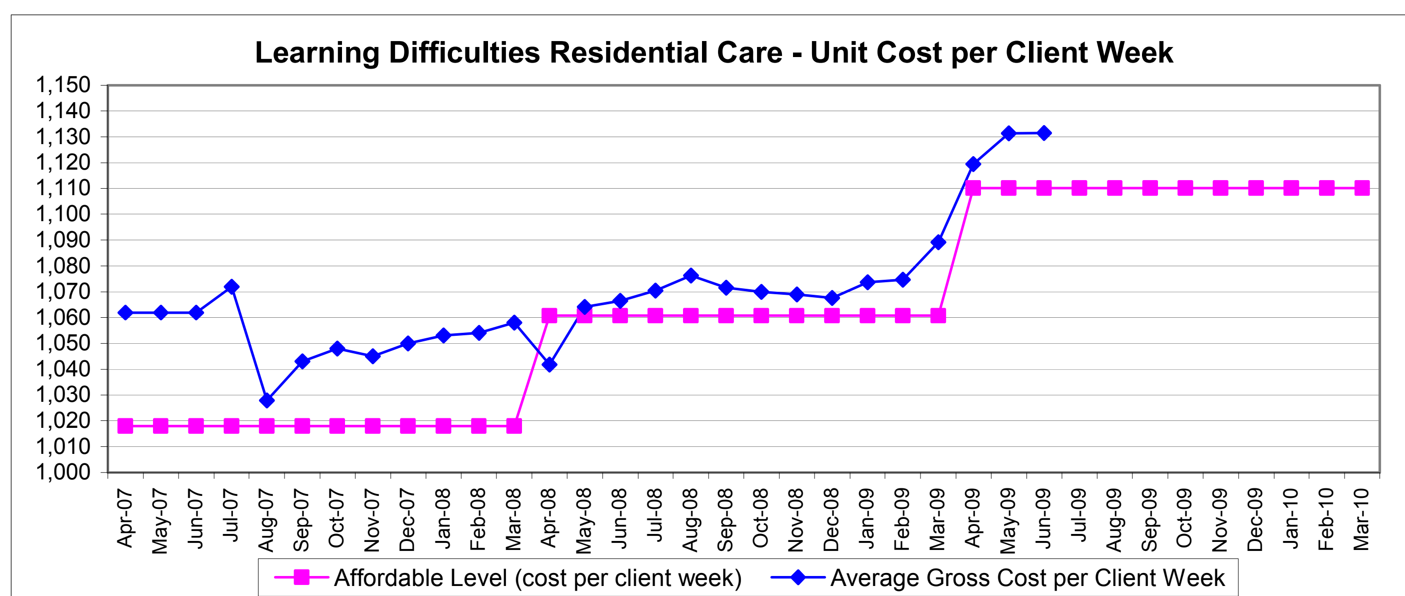
- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in LD residential care at the end of 2007-08 was 633, at the end of 2008-09 it was 640 (with some much higher numbers during the year) and at the end of June, 632.

- The forecast position of 33,308 weeks of care is some 652 weeks over the affordable level, indicating a pressure of £738k using a unit cost of £1,131.43. The forecast is based on the current activity as well as those known young people that will be coming to adult social services before the end of the year, plus an assumption about clients transferring out of residential care to supported living arrangements. Those young people in the "transition" process are known to Social Services as young as 14 and so they can be planned for, as highlighted in section 1.1.3.2.a.

- To the end of June 8,437 weeks of care have been delivered against an affordable level of 8,513, a difference of 76 weeks.

2.4.2 **Average gross cost per client week of Learning Difficulties residential care compared with affordable level (non preserved rights clients)**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Week)	Average Gross Cost per Client Week	Affordable Level (Cost per Week)	Average Gross Cost per Client Week	Affordable Level (Cost per Week)	Average Gross Cost per Client Week
April	1,018.00	1,062.00	1,060.70	1,041.82	1,110.15	1,119.42
May	1,018.00	1,062.00	1,060.70	1,064.19	1,110.15	1,131.28
June	1,018.00	1,062.00	1,060.70	1,066.49	1,110.15	1,131.43
July	1,018.00	1,072.00	1,060.70	1,070.50	1,110.15	
August	1,018.00	1,028.00	1,060.70	1,076.27	1,110.15	
September	1,018.00	1,043.00	1,060.70	1,071.59	1,110.15	
October	1,018.00	1,048.00	1,060.70	1,070.02	1,110.15	
November	1,018.00	1,045.00	1,060.70	1,068.95	1,110.15	
December	1,018.00	1,050.00	1,060.70	1,067.59	1,110.15	
January	1,018.00	1,053.00	1,060.70	1,073.71	1,110.15	
February	1,018.00	1,054.00	1,060.70	1,074.67	1,110.15	
March	1,018.00	1,058.00	1,060.70	1,089.10	1,110.15	



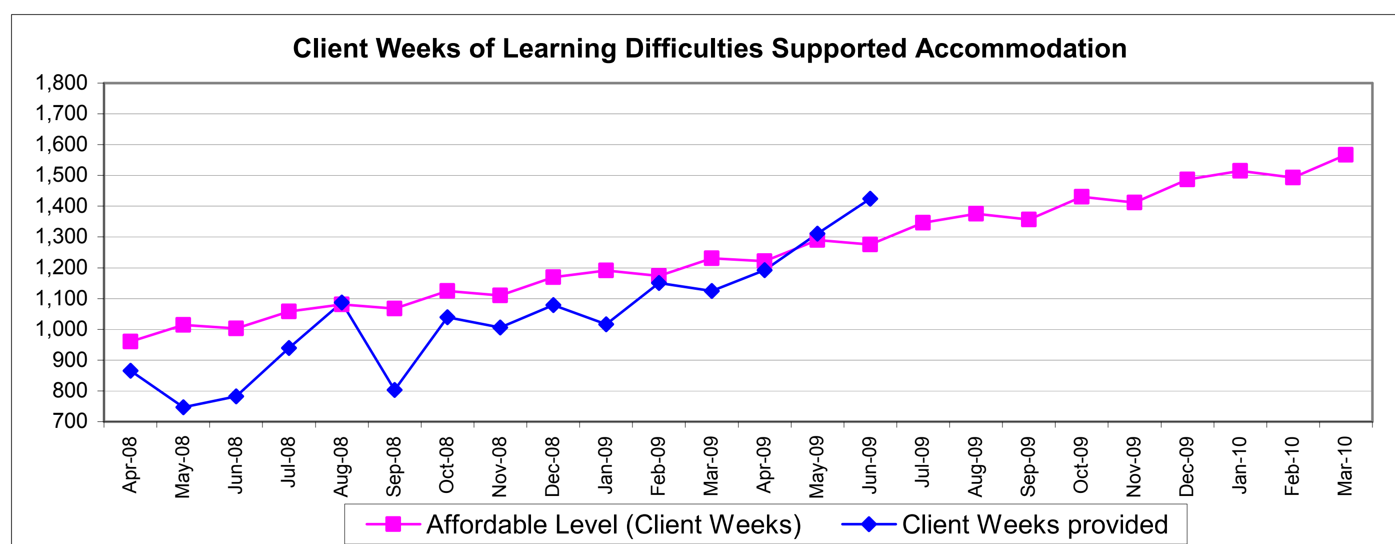
Comments:

- Clients being placed in residential care are those with very complex and individual needs which makes it difficult for them to remain in the community, in supported accommodation/supporting living arrangements, or receiving a domiciliary care package. These are therefore placements which attract a very high cost, with the average now being over £1,100 per week. It is expected that clients with less complex needs, and therefore less cost, can transfer from residential into supported living arrangements. This would mean that the average cost per week would increase over time as the remaining clients in residential care would be those with very high costs – some of whom can cost up to £2,000 per week. In addition, no two placements are alike – the needs of people with learning disabilities are unique and consequently, it is common for average unit costs to increase or decrease significantly on the basis of one or two cases.

- The forecast unit cost of £1,131.43 is higher than the affordable cost of £1,110.15 and this difference of £21.28 adds £695k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.2.a.

2.5.1 **Number of client weeks of learning difficulties supported accommodation provided compared with affordable level:**

	2007-08		2008-09		2009-10	
	Affordable Level (Client Weeks)	**Client Weeks of LD supported accommodation provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD supported accommodation provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD supported accommodation provided**
April			960	865	1,221	1,192
May			1,014	747	1,290	1,311
June			1,003	782	1,276	1,424
July			1,058	939	1,346	
August			1,081	1,087	1,375	
September			1,067	803	1,357	
October			1,125	1,039	1,431	
November			1,110	1,006	1,412	
December			1,169	1,079	1,487	
January			1,191	1,016	1,515	
February			1,174	1,151	1,493	
March			1,231	1,125	1,567	
TOTAL	**7,618**	**11,156**	**13,183**	**11,639**	**16,770**	**3,927**



Comments:

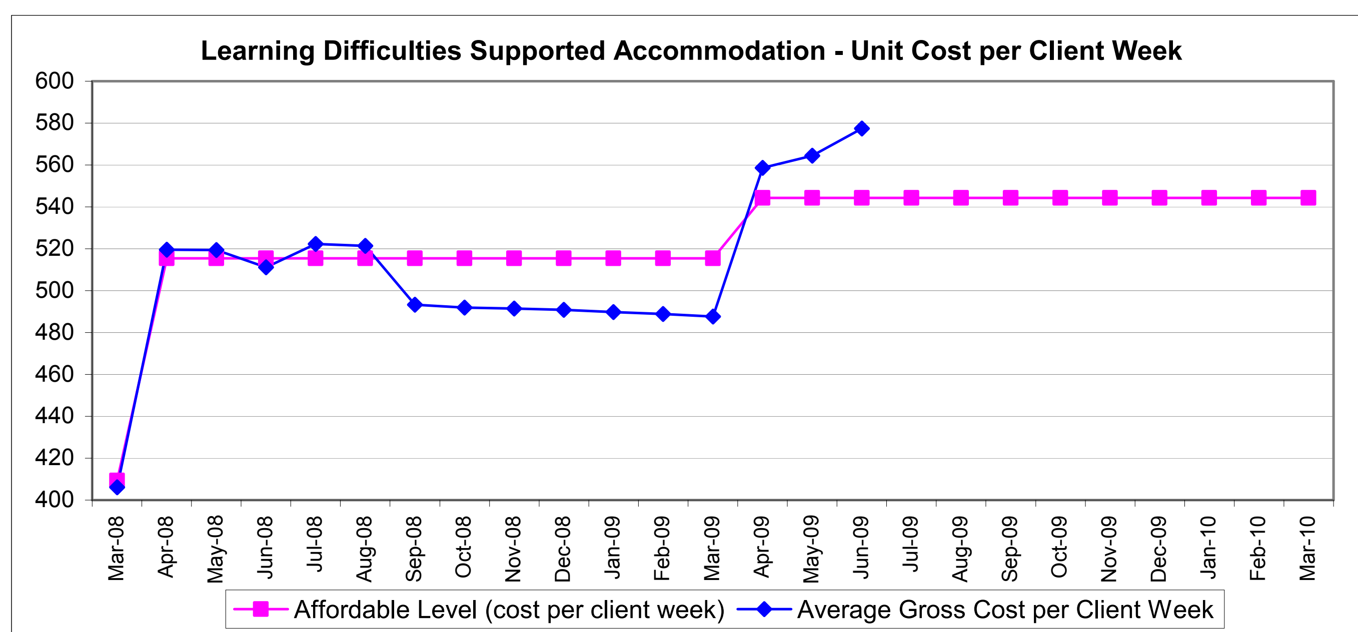
- The above graph reflects the number of client weeks of service. The actual number of clients in LD supported accommodation at the end of 2007-08 was 193 and at the end of March 2009 it was 233. As at the end of June, the numbers had increased to 276.

- The latest forecast position of 16,898 weeks against an affordable level of 16,770 weeks shows a difference of 128 weeks, which indicates a pressure of £74k using a unit cost of £577.33.

- Like residential care for people with a learning disability, every case is unique and varies in cost, depending on the individual circumstances. Although the quality of life will be better for these people, it is not always significantly cheaper. The focus to enable as many people as possible to move from residential care into supported accommodation means that increasingly complex and unique cases will be successfully supported to live independently. The forecast assumes further small increases in clients in the year.

2.5.2 **Average gross cost per client week of Learning Difficulties supported accommodation compared with affordable level (non preserved rights clients)**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April			515.41	519.60	544.31	558.65
May			515.41	519.40	544.31	564.49
June			515.41	511.10	544.31	577.33
July			515.41	522.30	544.31	
August			515.41	521.40	544.31	
September			515.41	493.33	544.31	
October			515.41	491.85	544.31	
November			515.41	491.47	544.31	
December			515.41	490.83	544.31	
January			515.41	489.75	544.31	
February			515.41	488.90	544.31	
March	409.31	406.18	515.41	487.60	544.31	



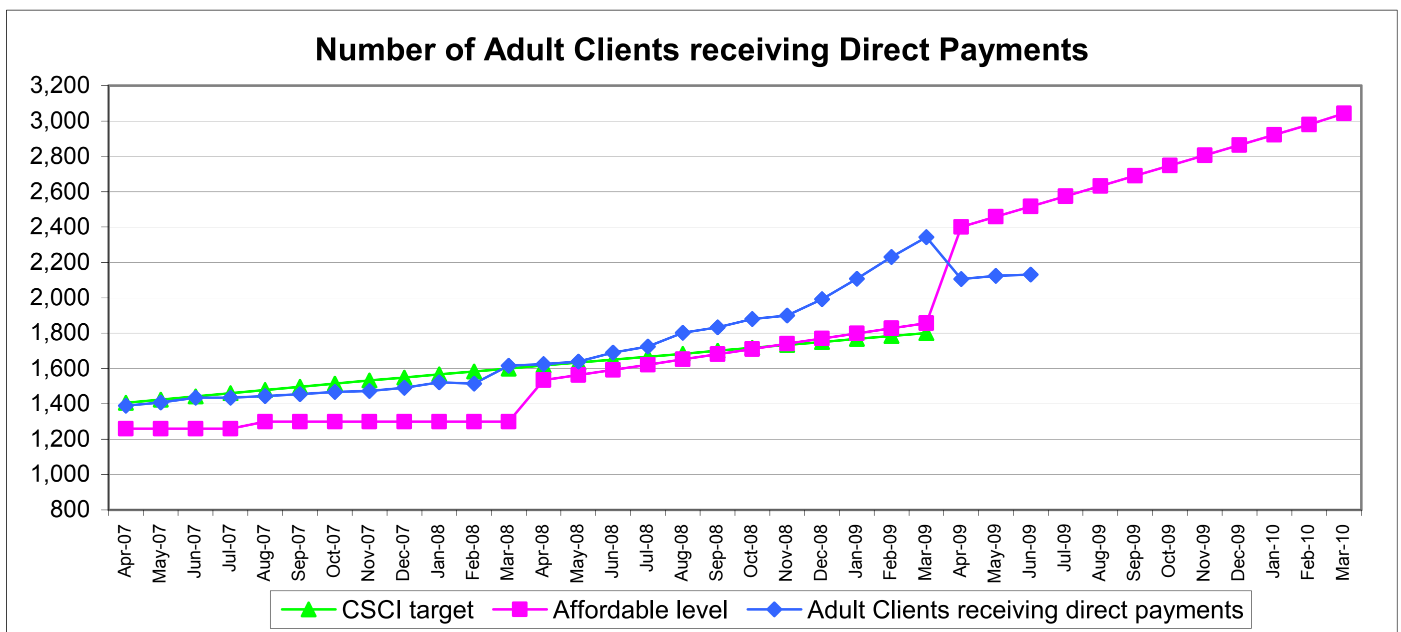
Comments:

- The forecast unit cost of £577.33 is higher than the affordable cost of £544.31 and this difference of £33.02 adds £554k to the position when multiplied by the affordable weeks as highlighted in section 1.1.3.2.b.

- The costs associated with these placements will vary depending on the complexity of each case and the type of support required in each placement. This varies enormously between a domiciliary type support to life skills and daily living support.

2.6 **Direct Payments – Number of Adult Social Services Clients receiving Direct Payments:**

	2007-08			2008-09			2009-10	
	CSCI Target	Affordable Level	Adult Clients receiving Direct Payments	CSCI Target	Affordable Level	Adult Clients receiving Direct Payments	Affordable Level	Adult Clients receiving Direct Payments
April	1,406	1,259	1,390	1,617	1,535	1,625	2,400	2,106
May	1,424	1,259	1,407	1,634	1,564	1,639	2,458	2,124
June	1,442	1,259	1,434	1,650	1,593	1,689	2,516	2,131
July	1,460	1,259	1,434	1,667	1,622	1,725	2,574	
August	1,478	1,299	1,444	1,683	1,651	1,802	2,632	
September	1,496	1,299	1,454	1,700	1,681	1,832	2,690	
October	1,514	1,299	1,467	1,717	1,710	1,880	2,748	
November	1,532	1,299	1,472	1,734	1,740	1,899	2,806	
December	1,549	1,299	1,491	1,750	1,769	1,991	2,864	
January	1,566	1,299	1,522	1,767	1,799	2,108	2,922	
February	1,583	1,299	1,515	1,783	1,828	2,231	2,980	
March	1,600	1,299	1,615	1,800	1,857	2,342	3,042	



Comments:

- From April 2008, the national measure for direct payments counted the permanent placements and the number of one-off payments within the year. The position reported for March 2009 represented the total activity for 2008-09 ie of the 2,342 adult clients reported as receiving a direct payment, 2,055 were in receipt of ongoing payments and 287 were clients that had received one-off payments at some point throughout the year. From April 2009, we are again counting the permanent placements and any one-off placements since April. However, this will not be directly comparable with the March 2009 position as we currently have only three months worth of one-off payments in the 2009-10 data compared to 12 months worth included in the March 2009 figure, and therefore it will appear lower. For purposes of comparison, the ongoing placements as at March were 2,055, as at June this had increased to 2,065.

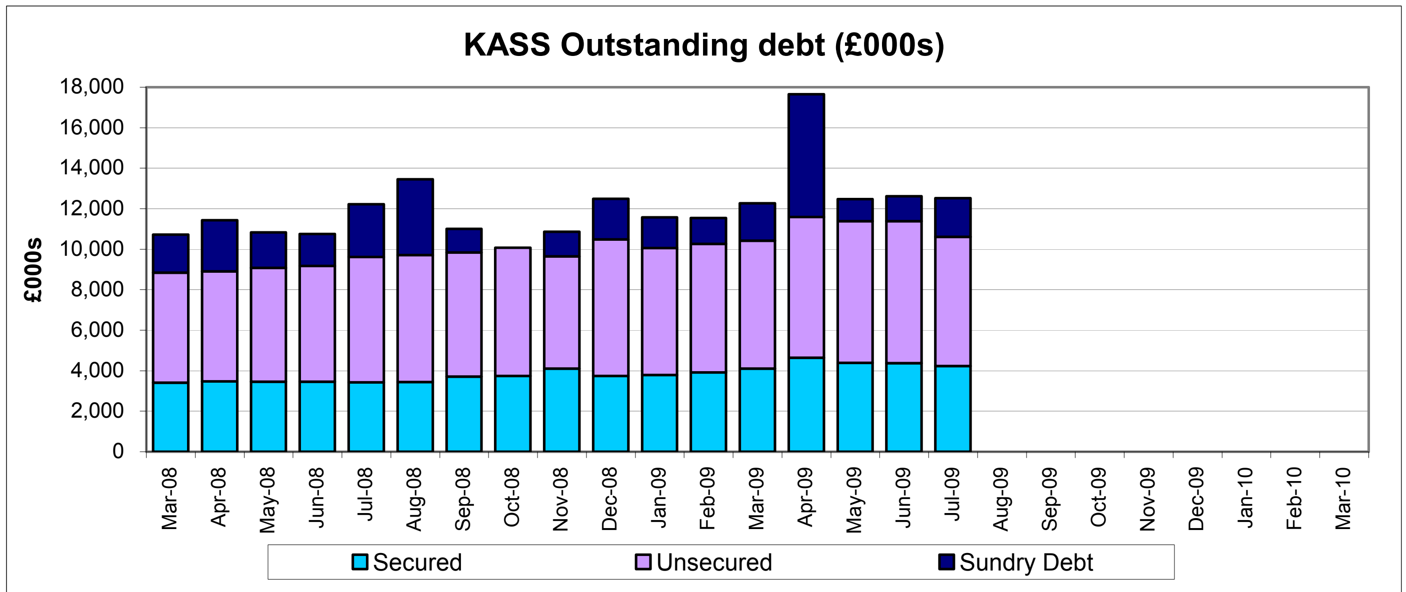
- From 2009-10, we no longer have a CSCI target for direct payments.

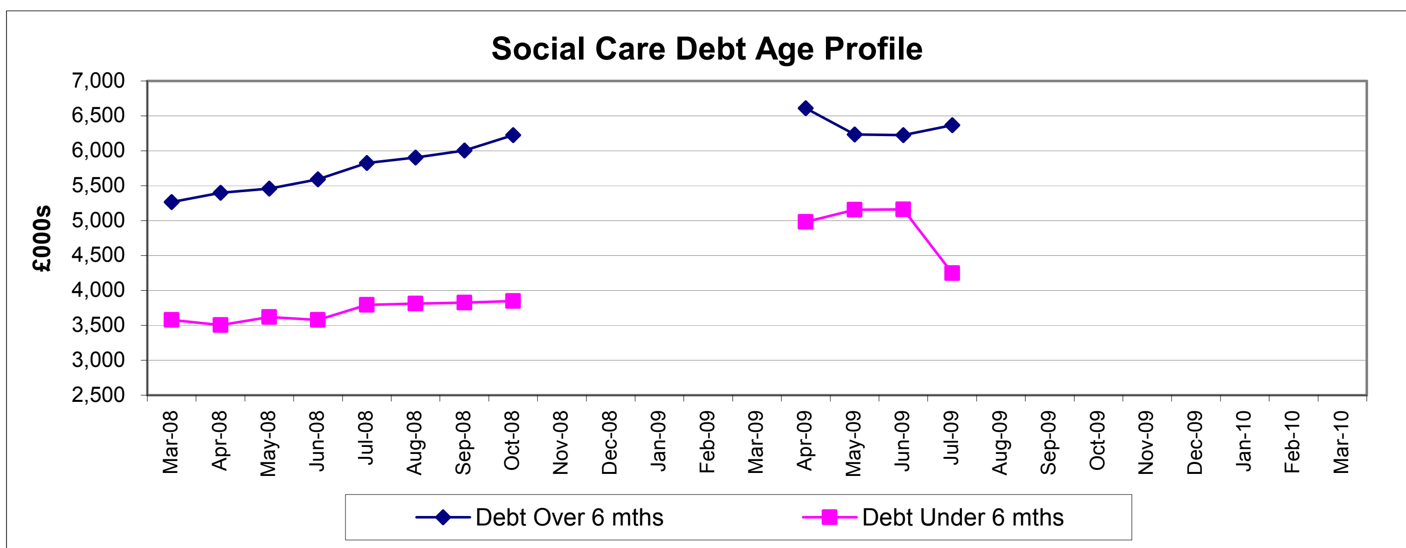
3. KASS OUTSTANDING DEBT

The outstanding debt as at July was £13.9m excluding any amounts not yet due for payment (as they are still within the 28 day payment term allowed). Within this is £12.0m relating to Social Care (client) debt and the following table shows how this breaks down in terms of age and also whether it is secured (i.e. by a legal charge on the client's property) or unsecured, together with how this month compares with previous months. For most months the debt figures refer to when the four weekly invoice billing run interfaces with Oracle (the accounting system) rather than the calendar month, as this provides a more meaningful position for Social Care Client Debt. This therefore means that there are 13 billing invoice runs during the year. It also means that as the Directorate moved onto the new Client Billing system in October 2008, the balance will differ from that reported by Corporate Exchequer who report on a calendar month basis, apart from the period November 2008 to March 2009, when the figures are based on calendar months, as provided by Corporate Exchequer, because reports at that time were not aligned with the four weekly billing runs. From April 2009 the debt figures revert back to being on a four weekly basis to coincide with invoice billing runs. The age of debt cannot be completed for the months between November 2008 and March 2009 as the switch to Client Billing meant that all debts transferring on to the new system became "new" for purposes of reporting therefore it was not possible to show ageing until April.

			Social Care Debt				
Debt Month	**Total Due Debt (Social Care & Sundry Debt) £000**	**Sundry Debt £000**	**Total Social Care Due Debt £000**	**Debt Over 6 mths £000**	**Debt Under 6 mths £000**	**Secured £000**	**Unsecured £000**
Mar-08	**10,727**	**1,882**	8,845	5,268	3,577	3,410	5,435
Apr-08	**11,436**	**2,531**	8,905	5,399	3,506	3,468	5,437
May-08	**10,833**	**1,755**	9,078	5,457	3,621	3,452	5,626
Jun-08	**10,757**	**1,586**	9,171	5,593	3,578	3,464	5,707
Jul-08	**12,219**	**2,599**	9,620	5,827	3,793	3,425	6,195
Aug-08	**13,445**	**3,732**	9,713	5,902	3,811	3,449	6,264
Sep-08	**11,004**	**1,174**	9,830	6,006	3,824	3,716	6,114
Oct-08	*	*	10,071	6,223	3,848	3,737	6,334
Nov-08	**10,857**	**1,206**	9,651			4,111	5,540
Dec-08	**12,486**	**2,004**	10,482			3,742	6,740
Jan-09	**11,575**	**1,517**	10,058			3,792	6,266
Feb-09	**11,542**	**1,283**	10,259			3,914	6,345
Mar-09	**12,276**	**1,850**	10,426			4,100	6,326
Apr-09	**17,874**	**6,056**	11,818	6,609	5,209	4,657	7,161
May-09	**12,671**	**1,078**	11,593	6,232	5,361	4,387	7,206
Jun-09	**12,799**	**1,221**	11,578	6,226	5,352	4,369	7,209
Jul-09	**13,862**	**1,909**	11,953	6,367	5,586	4,366	7,587
Aug-09	**0**						
Sep-09	**0**						
Oct-09	**0**						
Nov-09	**0**						
Dec-09	**0**						
Jan-10	**0**						
Feb-10	**0**						
Mar-10	**0**						

* In October 2008, KASS Social Care debt transferred from the COLLECT system to Oracle. The new reports were not available at this point, hence there is no data available for this period. The October Social Care debt figures relate to the last four weekly billing run in the old COLLECT system.





* The age of debt cannot be completed for the months between November 2008 and March 2009 as the switch to Client Billing meant that all debts transferring on to the new system became "new" for purposes of reporting therefore it was not possible to show ageing until April (i.e. once these debts became 6 months old in the new system).

This page is intentionally left blank

By: Graham Gibbens, Cabinet Member, Adult Social Services
Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services Policy Overview Committee – 22 September 2009

Subject: **TOWARDS 2010 – ANNUAL REPORT**

Classification: Unrestricted

Summary: This report sets out the process for finalising the third *Towards 2010* Annual Report prior to approval by County Council and attaches a draft of the report (for the five Kent adult social services-related targets) for Members' comment.

Introduction

1. *Towards 2010* was formally launched in September 2006. Annual reports on progress against all 63 targets are discussed and approved by County Council each autumn. The purpose of this report is to present the annual position of the five KASS targets and set out the process for finalising the Annual Report prior to presentation for approval to County Council on 15 October 2009.

2. Those Towards 2010 targets relevant to this committee are shown in the table below together with the relevant status:

Towards 2010 Target	Status
Target 52: Increase the number of people supported to live independently in their own homes. This will include: • encouraging the development of more housing for older people, disabled people and those with special needs • encouraging more people to take control of their care/support through Direct Payments • taking advantage of new technologies, such as expanding our TeleHealth and Telecare programmes	Done and Ongoing
Target 53: Strengthen the support provided to people caring for relatives and friends	On course
Target 54: Work with our colleagues in the health service to reduce the number of avoidable admissions to hospital and combine resources, where appropriate, to improve the health and well-being of the people of Kent	On course
Target 55: Ensure better planning to ease the transition between childhood and adulthood for young people with disabilities and to promote their independence	On course

Target 56: Improve older people's economic well-being by encouraging the take-up of benefits	On course

Please note that where targets are cross-directorate they will be reported to all relevant Policy Overview Committees.

3. The separate reports for each target include the following elements:

- Status of the target (either 'More progress needed', 'On course' or 'Done and ongoing')
- List of partners with whom we are delivering this target
- Outcomes delivered so far
- What more are we going to do to deliver the target
- Measurable indicators (where relevant – as agreed at County Council in December 2007).

Approval Process

4. The draft Annual Report will be discussed at the September meetings of all Policy Overview Committees to enable Members to comment on the early draft prior to its finalisation for the Cabinet and County Council meetings.

5. Each Policy Overview Committee will receive the draft reports on the relevant targets relating to their committee's accountabilities. Attached is a draft of the reports for the five Kent Adult Social Services-related targets in the above table.

Recommendations

6. Members are asked to **DISCUSS and APPROVE** the report

Lead Officer:

Nick Sherlock
Head of Planning and Public Involvement

Elouisa Matthews
Senior Planning Officer
(01622) 69**6369**

Background documents:
T2010 second year annual report. Taken to ASSPOC Sept 2008.

<table>
<tr><td colspan="3">Target 52: Increase the number of people supported to live independently in their own homes. This will include:
• encouraging the development of more housing for older people, disabled people and those with special needs
• encouraging more people to take control of their care/support through Direct Payments
• taking advantage of new technologies, such as expanding our Telehealth and Telecare programmes</td></tr>
<tr><td>Lead Cabinet Member:
Graham Gibbens</td><td>Lead Managing Director:
Oliver Mills</td><td>Lead Officers:
David Weiss, Cathi Sacco, Mike Dorman, Michael Thomas-Sam</td></tr>
</table>

Status: Done & Ongoing

List the partners with whom we are working to deliver this target:
The success of this target depends on a wide range of activity and partnerships. Partners include:

- 12 District Councils
- Registered Social Landlords
- Health - PCT's and Mental Health Trust
- Voluntary Agencies – who manage many of the support projects
- Private Sector – e.g. home care providers
- Training Providers such as local FE Colleges - delivering specialist courses on independence for care workers and personal assistants
- Other Statutory Agencies including Police and Ambulance Service

Furthermore the success of this target is closely linked with the performance of other targets in Towards 2010 – particularly those related to health issues in this section.

Outcomes delivered so far:
Housing to Promote Independence. A key aspect of this target is the development of suitable housing to enable people to live independently. A number of housing schemes catering for people with a whole range of needs from older people, through to people with learning disabilities have been developed through PFI's in partnership with District Councils (see previous Annual Reports for more detail). The outcome is based on current work and we fully expect there to be at least 417 new housing units built and ready for occupation by 2010.
Kent Adult Social Services is now represented at the Kent Housing Group and promotes this target with partner Housing Commissioners and providers in Kent.

Direct Payments are being actively promoted, leading to a significant increase in take up. There are now 2,342 people using Direct Payments in Kent. The Kent Card is now being used by 831 people as a banking option for Direct Payments. The outcome has been to give more people the opportunity to have control over the package of support which enables them to live independently.

TeleHealth and Telecare. These are preventative interventions which embrace new technology to enable people to remain in their own homes. As documented in detail in previous reports, Kent has been a Whole Systems Demonstrator (WSD) site (only 3 were selected by Department of Health). Kent already were forerunners in the development of such interventions and the WSD project enabled Kent to offer the benefits of TeleHealth and Telecare to far more people. The outcome will be for 1,000 extra people to be offered Telecare and 1,000 extra people to be offered TeleHealth. The majority of this work will be completed by the end of the year. The programme end date is July 2010.

Localised Community Based Prevention. KCC continues to invest in a wide range of innovative preventative schemes. These include:

- *Brighter Futures*, which encourages more able older people to support more needy people through volunteering. Originally piloted in West Kent this is now being expanded across the County, but ensuring each project is tailored for its local community.
- INVOKE – described in more detail in Target 54.
- A whole range of local projects often delivered by the Voluntary Sector focusing on a wide range of issues from dementia to 'falls' projects.

The outcome has been to enable more people to remain independent. Evidence of this can be seen in the recent Care Quality Commission Inspection of Kent Adult Social Services[1].

Active Lives for Adults (ALfA) is a major change programme focussed on promoting personalisation and independence. In short, enabling people to have more choice and control. New services built around this ethos are being implemented including:

- Enablement services[2] have been extended substantially. These services are provided in peoples' homes and are aimed at providing a quick, time limited, response to people who need help to regain their confidence and skills in order to remain independent in their home.
- The Good Day Programme which is transforming day support for people with Learning Disabilities, offering more opportunities and choice.

Safeguarding. To enable people to live independently it is important people feel safe from abuse. KCC with it its partners have a strong multi- disciplinary Board which has led on ensuring that safeguarding vulnerable adults is a high priority. Further evidence to support this can be seen in the recent inspection report[3].

What more are we going to do?

Promoting Independence continues to be the overall objective which will be driven by Active Lives for Adults. This is a programme of total transformation for all of Kent Adult Social Services whether directly provided or commissioned from other agencies. It will deliver a structure and culture that supports people to develop solutions to their needs, from an increasingly responsive and diverse market place. Fundamental to this is Self-Directed Support (SDS), whereby people can self manage their support or, if they choose to, have somebody else (including Kent Adult Social Services) manage it for

[1] Independence Wellbeing and Choice Inspection
[2] See previous Annual Reports for more detail.
[3] Independence Wellbeing and Choice Inspection

them. KASS is currently in the middle of implementing this major programme and it will be progressively rolled out during 2009/10.

Fast Track Equipment. Last year a new innovation of enabling delivery of core equipment through the County Duty Service was piloted. It proved successful and is now being rolled out across the County. This fast-track system allows equipment to be delivered quickly following first contact. It will also extend to deal with NHS requests. The outcome of this is to enable people to have fast access to equipment, vital in maintaining independence.
As part of the ALfA programme a strategic review of older people services is being undertaken to ensure that these services are shaped to meet the challenges of personalisation and Self- Directed Support.

Housing. Based on the success of Better Homes/Active Lives we have, in partnership with 5 District Councils, developed another PFI bid to deliver 228 units of social housing for vulnerable people.

A Housing Action Plan has been developed to focus on the needs of peo0ple with Learning Disabilities as part of ‘Valuing People Now’ and implementation of this has begun. The Outcome is to ensure suitable housing solutions are available to enable people with Learning Disabilities to be independent

Telehealth & Telecare. These will continue to be a significant part of our preventative strategy and will continue to expand. The outcome will be to enable more people to be supported independently.

Community based Preventative Services. We will continue to develop preventative services with the private and voluntary sector in partnership with the Health Service. The outcome of this continued work will be to enable more people to live independent fulfilled lives within their community.

Safeguarding. Following the Independence Wellbeing and Choice Inspection an action plan has been agreed with the Care Quality Commission which will further improve the safeguarding in Kent

Measurable Indicator (s)	2005/06	2006/07	2007/08	2008/09	2009/10 Target
Number of people supported by community based services provided by Kent Adult Social Services (including through voluntary sector funding) to live independently, as at 31 March each year	31,027	31,990	32,983	35,473	34,027

Monitoring completed by: Lead Officers **Date:** July 2009

Target 53: Strengthen the support provided to people caring for relatives and friends		
Lead Cabinet Member: Graham Gibbens	Lead Managing Director: Oliver Mills	Lead Officer: Michael Thomas-Sam, Cathi Sacco, Mike Dorman

Status: On course

List the partners with whom we are working to deliver this target:

- Children, Families and Education Directorate
- Communities Directorate
- Kent Children's Fund
- Carers Support Organisations
- University of Kent
- NHS
- Jobcentre Plus (JCP)
- Kent Drug and Alcohol Team (KDAAT)
- Independent providers

The success of this target is closely linked with the performance of other targets in Towards 2010 – particularly those related to health issues in this section.

Outcomes delivered so far:

The Select Committee Report "Carers in Kent" January 2008 set 14 recommendations for Kent. It was reviewed in January 2009. Many of these recommendations as illustrated in the previous Annual Report have been implemented. The outcome of the Select Committee has been to stimulate and give direction to the activity which supports this target.

Kent Adult Carers Strategy was launched in July 2009; the strategy is Kent's response to delivering the National Carers' Strategy which was published in June 2008. There are five outcomes:

- Improving Information Advice and Guidance
- Access to integrated and personalised services
- Carers having a life of their own
- Carers not being forced into financial hardship
- Helping Carers to stay mentally and physically well

The outcomes will be delivered via multi-agency joint commissioning plans. There will be two plans, one for East Kent and one for West Kent. The NHS, Jobcentre Plus and KDAAT have identified Carers Leads who are working in partnership with KASS to deliver the Kent Adult Carers' Strategy and associated commissioning plans. The plans are due to be completed in autumn 2009.

An Annual Carers Report was launched alongside the Kent Adult Carers' Strategy in July 2009. This report has for the first time:

- Captured the true nature of the support offered to carers in Kent.
- Showed the range and depth of support offered across all sectors.

Kent Carers Emergency Card Scheme was launched in December 2008. The aim of the scheme is to:

- Provide carers with peace of mind when away from the person that they care for.
- Offer carers as much support as necessary to complete their emergency plan.
- Ensure that County Duty or the Out of Hours service will step in to arrange emergency support if the plan fails.
- Ensure that this support is available to all carers not just those carers of people receiving community care services.
- Increase levels of community based respite.

Currently there are over 750 carers signed up to the scheme and the number is growing steadily and the feedback regarding the scheme has been positive.

The Mental Health Matters help-line is now funded from 5pm to 9am on weekdays and 24hrs weekends and holidays. The service is available to carers, and referrals can be made to the Crisis Resolution and Home treatment Teams. This has also received positive feedback.

A Mental Health carer's support group is funded in each locality in Kent. These provide:

- Advice, support and information to carers of people with functional mental health problems
- One to one support for Carers
- Carers Support groups that meet regularly
- Carer's participation in the decision making meetings about the commissioning of mental health services
- Carers Assessment Workers
- Funding for Carers breaks

KASS Carers Assessment Policy was revised in April 2009. This resulted in a trial to outsource the Carers' Assessment to Carers Support Organisations in two pilot sites, Tonbridge and Dover. With the pilot due to end in April 2010 evaluation will take place on a three monthly basis.

Young Carers Strategy 'invisible people' was launched in July 2008 with the following outcomes:

- Guidance has been issued to all schools
- The voice of Kent young carers has been captured by DVD which highlights young carers' issues in training for professionals
- A joint young carers' protocol has been agreed between Kent Adult Social Services and Children, Families and Education to clarify referral routes across Directorates. Training is to begin in Autumn 2009.

The KCC Staff Carers' Leave pilot scheme has been well received and was launched to all staff in June 2009.

KASS provide a range “short breaks” which benefit carers and the people they support. These include:

- Day care
- Support in the home
- Overnight care
- Adult placements
- Emergency breaks

Information about the number and range of carers services delivered and people support is presented in the Annual Report.

What more are we going to do?

A Carers Advisory Group in Kent has been formed bringing together all the key strategic partners involved in supporting carers together.

Within KASS, training is underway to reinforce the policy implementation and further clarifying duties and responsibilities towards carers to create a far more consistent approach to the assessment and support offered to carers.

West Kent NHS and Kent Adult Social Services have also been successful in its bid to become a Department of Health Carers’ Strategy Demonstrator Site which will bring in about £410,000 over two years.

A group of Carers Support Organisations across Kent has been successful in a bid, fully supported by KASS, to be a pilot site for Caring with Confidence training. This training will form part of learning opportunities developed in conjunction with the joint commissioning plans to ensure that carers are supported as expert partners in care. The first facilitator training has now been completed and the program is expected to commence in the immediate future.

We are exploring mechanisms for information sharing across health, social care and the voluntary sector. Carers Assessments have been considered in discussions regarding Kent Adult Social Services decisions to procure a Common Assessment Framework.

We will continue to develop services, which meet the needs of carers in line with the Select Committee recommendations.

KASS have identified £30,000 for Kent Drug And Alcohol Team to use in order to support carers of people with drug / alcohol problems

KCC, as an employer, is surveying staff to gain an insight into the number of employees juggling caring with employment. The survey will explore if staff would like a Carers’ Staff Forum to be developed.

In addition to the staff survey, Kent Adult Social Services conducted a survey of Carers across Kent, the results were published in July 2009. The purpose of the survey was to measure how satisfied Carers are, with the services they receive from Kent Adult Social Services.

Measurable Indicator (s)	2007/08 Actual	2008/09 Estimate	2008/09 Actual	2009/10 Target
Satisfaction– based on carer survey. Results published July 2009	New indicator	N/A	68%	70%

Monitoring completed by: Lead Officers **Date:** July 2009

Target 54: Work with our colleagues in the health service to reduce the number of avoidable admissions to hospital and combine resources, where appropriate, to improve the health and well-being of the people of Kent		
Lead Cabinet Member: Graham Gibbens	Lead Managing Director: Oliver Mills	Lead Officers: Nick Sherlock/ Cathi Sacco/ Mike Dorman

Status: On course

List the partners with whom we are working to deliver this target:
The main partners in delivery of this target are the NHS in Kent, particularly the 2 PCT's and the Mental Health Trust. However, the Voluntary and Private Sector in managing many of the community based projects and the District Councils all make significant and valuable contributions to this target.
Furthermore the success of this target is closely linked with the performance of other targets in Towards 2010 – particularly those related to health issues in this section.

Outcomes delivered so far:
KCC has a strong tradition of working closely with the Health Service as evidenced by the established section 75 partnerships. Outlined briefly are some initiatives delivered within the context of this target along with outcomes. More detailed evidence for each of these can be provided if required.

- Joint Commissioning with PCTS. There are Joint Commissioning arrangements in both East Kent and West Kent and Mental Health. There are also Quarterly SMT Meetings. Furthermore, a number of jointly appointed commissioning posts have been established. The outcome is that PCT's, KMPT and KASS have shared priorities at Strategic and Local Levels and resources to commission services to meet these priorities. Evidence of this are the shared cross cutting targets in Kent Agreement 2 (LAA).
- Joint Strategic Needs Assessment. This has been developed as a tool which is being used in identifying joint commissioning priorities. Underneath the overarching JSNA, specialist assessments have been developed around such areas as dementia and mental health. The outcome of these activities has been to ensure that identified priorities and commissioning have been developed from an evidenced based needs assessment.
- Public Health Department. This is now firmly established and led by a jointly appointed Public Health Director. Its agenda for action is set out in The Public Health Strategy (Live Life to the Full) and the Public Health Annual Report. The outcome of the Public Health Department has been to see a wider focus on prevention and health inequalities and develop new ways of working with the Health Service and communities. Such projects as Active Mobs are evidence of this.
- INVOKE[4] (Independence through the Voluntary action of Kent Elders) is the project that has been developed out of the successful Partnerships for

[4] More detail on this project have been provided in previous Annual Reports

Older People bid. This project has introduced a range of initiatives which have supported older people in the community. There are a range of outcomes, which have been drawn out through research and this includes reduction in overnight stays in hospital to ensuring people within the project have received all their benefits.

- Prevention in the Community. Projects in partnership with Health and through joint investment in the Voluntary Sector. This includes *Brighter Futures*, which encourages more able older people to support more needy people through volunteering. Other initiatives range from community support to those with dementia to 'Falls' projects. The outcome has been to enable more people to remain independent. Evidence of this can be seen in the recent Care Quality Commission Inspection of Kent Adult Social Services[5].
- TeleHealth and Telecare. The partnership with Health in developing the Whole Systems Demonstrator, already described in detail in Target 52, is another initiative which is supporting the development of this Target. The outcome of this is to improve the independence, health and wellbeing of people through the use of new technology. This was also evidenced in the recent inspection[6].
- Reducing delayed transfer of care continues to be an area of high priority across health and social care. There are a whole range of joint initiatives, including Intermediate Care, Enablement, and Rapid Response. Many of these have been described in more detail in previous Towards 2010 reports. The outcome has been to reduce the level of delayed discharges from hospital. This was recognised by the Health Overview and Scrutiny Committee in October 2008 and through the evidence presented to the Care Quality Commission[7].
- Intermediate Care . In partnership with Health we have developed a wide range of intermediate care projects the objectives of intermediate care are preventing avoidable hospital admission, facilitating safe early discharge from hospitals and maximising people's ability to regain their independence. Intermediate care has played a significant part in tackling delayed discharges from hospital and enabling people to live independently
- Learning Disability. Approximately 400 people will transfer from the NHS to KASS under the Section 256/NHS ACT 2007. This is a huge project which has been outlined in detail in previous Towards 2010 reports. The outcome of this project will be to give this group of people more opportunities of choice and independence. The transfer is rooted in the principles of Valuing People.

The vast majority of the above initiatives will be developed beyond 2010 continuing to deliver better outcomes for people.

---

[5] Independence Wellbeing and Choice Inspection
[6] Independence Wellbeing and Choice Inspection
[7] KASS submission to CQC for the Annual Review Meeting 30 June 2009

What more are we going to do?
The major priorities for the next three years focus on working with Health in delivering more personalised services which offer people choice and control – Self Directed Support. A key feature continues to be a focus on community based preventative services, in order to deliver joint priorities outlined in such Strategies as the Carers Strategy, The End of Life Strategy and the Dementia Strategy. A key feature will be the development of shared pathways of care planned jointly. Outlined below are some planned initiatives delivered within the context of this target along with outcomes:

- Mental Health Trust – already well established, the Trust is applying for Foundation Status and the outcome will be to give the Trust more flexibility in setting Local Priorities and commissioning services.
- Joint Commissioning Posts. In line with the major changes needed to implement Self-Directed Support, in partnership with the PCT's, further joint posts focused on strategic commissioning are being established. The outcome of this will be to ensure an integrated approach to commissioning focused on shared priorities.
- Implementation of The Carers Strategy jointly with the PCT's. The outcome will be to put in place more support for carers.
- Whole Systems Demonstrator / Telecare / TeleHealth. The continued implementation of this project will deliver further opportunities for people to use technology to enhance their independence and wellbeing.
- Autistic Spectrum. Recently the KCC have held a Select Committee on this issue and the recommendations have now been published and we will be working jointly to improve the services for this group.
- Common Assessment Framework. We are working with the NHS to develop this through Functional Assessment in Care Environments (FACE). This will mean that we will have a joint co-ordinated assessment process whereby people will only have to answer questions once about their circumstances.

Measurable indicators:

None – This Towards 2010 target has been formally agreed as having an 'aspirational' status and progress is measured via qualitative means.

Monitoring completed by: Lead Officers **Date:** July 2009

Target 55: Ensure better planning to ease the transition between childhood and adulthood for young people with disabilities and to promote their independence		
Lead Cabinet Members: Graham Gibbens/Sarah Hohler	Lead Managing Directors: Oliver Mills/Rosalind Turner	Lead Officers: Michael Thomas-Sam/Colin Feltham

Status: On course

List the partners with whom we are working to deliver this target:

Kent Adult Social Services (KASS) and Children, Families and Education (CFE) are leading the partnership which includes the Kent Learning Disability Partnership Board, Parent Organisations, Primary Care Trusts, Learning Skills Council, Connexions and Schools. We are expanding the partners to include KCC's Communities Directorate, local Further Education Providers and District Councils.

Outcomes delivered so far:

A major driver for the work to support this Target was the Select Committee from which a number of successful initiatives have sprung, overseen by the Transition Board. The
Multi-Agency Transition Protocols are an example of this.
The Protocols set out the clear commitment to every disabled young person in Kent that they will get co-ordinated support to help them move from adolescence to adulthood. The protocols ensure that this transition support will be personalised, co-ordinated around individual needs and reflect the young person's aspirations. The protocol also ensures that young people, their families and the professionals involved all have a clear understanding of who will be involved and what they will do.

Young people who may need additional support with their transition into adult life will be identified as they have their Transition review in Year 9. With the young people and their carer's consent, this links together basic identifying information held by Education, Health and Social Care agencies. It will ensure that no-one who needs and wants support through transition will be missed.

Training to support the implementation of the Transition Protocols, across all agencies, has been delivered in every locality. This is building on the best practice already within the county and developing local virtual teams who will lead on transition for the local children. The effectiveness of these is being monitored by all the agencies involved.
All the above actions will ensure that the practice around transition is improved upon.

The Young People, Carer and Easy-Read Guides to the Transition Process have been distributed through a network of professionals so that it will be available to every young person who needs it. This will ensure that every young person and their families will know what support they will receive and how to access it. It is also available on each agency's websites and at www.kent.gov.uk/transition.

The effectiveness of the support given through transition, and the implementation of the Transition Protocols, has been monitored by satisfaction surveys. In the last 6 months, 106 young people or their carers have been asked to rate their satisfaction with the support they have received in the 4 key areas of:

- Involvement of appropriate agencies
- Provision of sufficient information, advice and guidance
- Young person's views and aspirations being central to the process
- Satisfaction with the current support

The percentage of people who said they were happy or very happy ranged from, 77% who were satisfied with their current support, to 68% who said they were satisfied that their views and aspirations were listened to.
Overall 73% said that they were either happy or very happy with the support they have received.

What more are we going to do?

The experiences of young people during and after transition will continue to be monitored. Further groups of young people and their carers will be asked to rate their satisfaction with their support to ensure that the protocols are making an improvement.

The training to support the implementation of the Transition Protocols, across all agencies will be extended to include mainstream schools so that the local virtual transition teams pick up all young people with disabilities who will benefit from supported transition.

The effectiveness of the support will continue to be monitored by asking young adults and their carers how satisfied they were. This will provide a rolling measure as the impact is more widely felt.

The significant increase in uptake of Direct Payments from CFE will continue to be built on and work is ongoing to ensure that the transition from a CFE Direct Payment to a KASS Personal Budget is managed smoothly. This increases both flexibility and control for individuals, enabling them to live their lives more independently. With the development of Self-Directed Support, Personal Budgets will become the norm for every adult needing support.

The Transition Partnership will be widened to include representatives from the District Councils, housing associations and employment and training organisations. This will increase the opportunities for young people to move to full adult life with more integrated access to housing and employment opportunities.

Measurable Indicator (s)	2007/08 Actual	2008/09 Target	2008/09 Actual	2009/10 Target
Satisfaction measure being developed based on user survey	New indicator	N/A	73%	80%

We will ensure that the outcomes achieved by this Towards 2010 target are supported by other Targets:

- Develop multi-agency support to parents and their children (Target 13)
- Listen to young people's views (Target 14)
- Increase the number of people who are supported to live independently (Target 52)
- Strengthen the support to people caring for relatives and friends (Target 53)

Monitoring completed by: Lead Officers Date: July 2009

Target 56: Improve older people's economic well-being by encouraging the take-up of benefits		
Lead Cabinet Member: Graham Gibbens	Lead Managing Director: Oliver Mills	Lead Officer: Michael Thomas-Sam

Status: On course

List the partners with whom we are working to deliver this target:
Our partners include the Pension Service, District Councils, Kent Benefits Partnership and Voluntary Organisations e.g. Age Concern, CAB, Citizens Rights for Older People.

Outcomes delivered so far:
Older people receiving social care services from KCC are offered information, advice and, if necessary, assistance to claim all the benefits they are entitled to. We have increased the effectiveness of this work by creating specialist teams and by working with the Pension Service, District Councils and local voluntary organisations. In addition we have provided extra funding to the 12 Citizens Advice Bureau in Kent which will enable them to help more people claim the benefits to which they are entitled.

All of our partnership working is contributing to the increase in benefit take up for older people in Kent. We have been provided with the following information from the Pension Service (part of the DWP that deals with people over 60). As a direct result of joint working with the Pension Service between April 2007 and 31 March 2009 £2.1 million in additional benefits was raised for Kent residents. Broken down this is £885,000 in Pension Credit, £898,000 in Attendance Allowance, £98,000 in DLA, £127,000 in Housing Benefit and £93,000 in Council Tax Benefit. In addition to monetary gain, joint working leads to a better experience for our service users who receive a quicker and less time consuming service.

Many of the Community based preventative projects run by the Voluntary Sector are working with older people to maximise their benefits, as are initiatives such as INVOKE and Brighter Futures described in previous Targets.

What more are we going to do?
We will continue to work with the Pension Service and District Councils to target those older people not receiving all their benefit entitlement. This includes working in the new Gateways and taking part in media campaigns targeted specifically at older people in Kent.

There is always a time lag before figures are available from the DWP. In addition there have been particular problems with data on Council Tax Benefit. The DWP have informed us that this data will be available by the end of the year.

Measurable Indicator (s)	Aug 06	May 07	May 08	Nov 08	May 09	2009/10 Target
Number of older people who are in receipt of /with underlying entitlement to Attendance Allowance	34,500	35,600	37,510	38,750	Not avail	+5% 36,225
Number of older people who are in receipt of Pension Credit	70,270	70,720	70,980	71,310	Not avail	+5% 73,783
+Number of older people in receipt of council tax benefit	61,690	62,540	Not available	Not available	Not avail	+5% 64,774

Monitoring completed by: Lead Officer **Date:** July 2009

This page is intentionally left blank

By: Graham Gibbens, Cabinet Member, Adult Social Services
Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services Policy Overview Committee – 22 September 2009

Subject: **END OF YEAR RESULTS FOR PERFORMANCE 2008-09**

Classification: Unrestricted

Summary: This report updates Members on the results for Kent Adult Social Services' performance indicators.

Introduction

1. (1) The Adult Social Services Directorate has a statutory duty to provide performance information to the Department of Health on an annual basis. A wealth of information is provided via a number of statutory data returns, which produces our performance indicators. In addition, the annual Self-Assessment Statement provides information about all aspects of our approach to strategic management, policy, service management, planning and customer care across all client groups. Regular meetings with Care Quality Commission (CQC) colleagues also provide the opportunity for discussion about the issues the Directorate faces and our plans to improve performance.

(2) The performance indicators are an important part of the Performance Assessment Framework, although not the whole story as explained above. They are assessed by CQC and form part of the annual assessment cycle, which culminates in the Annual Review Meeting with the CQC Business Relationship Manager and the Regional Director.

(3) This year has been the first year of a new national performance framework and is being treated as a "transition" year by both CQC and the Department of Health. Essentially, the new framework has seen a reduction in the number of indicators required for each Local Authority, but focuses on the areas of performance that would evidence better outcomes for service users.

(4) This new streamlined approach fits with the personalisation of social care more appropriately than the old framework and was welcomed by Kent.

(5) The Department of Health have announced that Local Authorities have experienced a reduced burden in producing statistics. Although the performance indicators are reduced, the resource needed to produce the statistical information which underpins this has not reduced significantly.

Results for 2008/09

2. (1) Results for 2008-09 can be seen at Appendix A, which also outlines what each indicator measures.

(2) The results represent good progress against some of our key priorities. In particular, the Directorate has delivered:

- Over 2500 direct payments in the year.
- Significant reduction in delayed transfers of care.
- Nearly 25,000 assessments completed within 28 days (9% higher than last year).
- Nearly 12,000 carers with a service, support or advice. Kent is one of the top performance authorities for assisting carers.
- Nearly 10% of all people with a learning disability have been helped into some form of employment, an increase on previous years.
- 75% of older people receiving intermediate care after discharge from hospital are living at home independently three months later.

(3) Current information suggests that there are variations amongst local authorities for some of these indicators. This was to be expected since this is the first year of the new Performance framework. This was especially so for NI145 – People with learning disability in stable accommodation. Variations for this indicator reflect the lack of clarity with the definition and a six-month collection period. However, based on very draft performance information, Kent's performance for this indicator is in line with the average.

The Assessment process

3. (1) This year, there will not be the publication of the star ratings for any authority. The assessment outcome following the Annual Review with CQC will feed directly into the Comprehensive Area Assessment (CAA) process.

(2) CQC has assessed our overall performance, together with our inspection assessment and additional evidence that we have provided to demonstrate the progress we have made at a local level for achieving better outcomes for people. This includes service user involvement, preventative and rehabilitation services, safeguarding and promoting personalisation and choice.

Data collection

4. (1) Kent Adult Social Services has managed performance at a local level for many years through its service user database, and so is able to produce detailed performance information at a local level to enable managers to evidence the success of these initiatives and demonstrate better outcomes for people.

(2) The quality of the data is critical to ensuring that performance information allows for accurate analysis of demand and service provision, but also so that it allows for managers to make the right decisions about support for people, expenditure and commissioning services.

(3) Last year, Price Waterhouse Cooper conducted an audit of data quality across the council, which was presented at the Governance and Audit Committee. KASS were able to demonstrate its robust measures and processes that are in place to ensure that data is accurate and accountability is taken for data quality by staff across the Directorate. In addition, in supporting the Cabinet Member for Adult Social Services, a regular update is provided for performance issues, including how data is validated and any particular data quality issues if they arise.

Targets

5. (1) Unlike previous years, there is a national requirement to set a target for only the indicators that have been chosen to be part of the Local Area Agreement (LAA). The indicator that KASS is responsible for relates to intermediate care (NI125).

(2) However, as a Directorate, we continually strive to enhance performance, and so continue to set targets, which are communicated across the Directorate. These can also be seen on the table at Appendix A. A six monthly report will be presented to the Adult Social Services Policy Overview Committee (ASSPOC) to highlight progress against these.

Recommendations

6. (1) Members are asked to NOTE KASS's performance indicators for 2008-09

Steph Abbott
Head of Performance and Management Information
01622 69**1796**

Background documents: None

APPENDIX A

New Kent Adult Social Services performance indicators 2008-09					
Indicator	**Title**	**Description**	**2008-09 result**	**Target for 2009-10**	**Comment**
NI 125	Achieving independence for older people through rehabilitation / intermediate care (LAA)	Percentage of Older people who are in their own homes three months after receiving intermediate care	**75%**	**77%**	This is our LAA target
NI 127	Self reported experience of social care users	User survey - satisfaction levels - not being used this year	**N/A**		
NI 130	Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)	Number of people receiving a direct payment per 100,000 population	**211**	**270**	This represents an increase from 2342 direct payments to 3000
NI 131	Delayed transfers of care from hospitals	Average number of delays per 100,000 population in a year	**29***	**29**	To maintain the significant improvement in 2008-09
NI 132	Timeliness of social care assessment	Percentage of assessments that take place within 4 weeks	**83%**	**85%**	Improve timeliness
NI 133	Timeliness of social care packages	Percentage of care packages delivered within 4 weeks	**95%**	**95%**	Maintain performance
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	Percentage of service users who have a carer receiving support.	**29%**	**29%**	Maintain high levels of supporting carers.
NI 136	People supported to live independently through social services (all ages)	The number of adults (18 and over) per 100,000 population that are assisted directly through social services funded support to live independently, plus those supported through grants funded services from local government.	**3062**	**3062**	Maintain levels of people supported independently. This will not include the increasing number of people that have been successfully enabled to return home without a care package.
NI 145	Adults with learning disabilities in settled accommodation	Percentage of People with a learning disability in settled accommodation	**37%**	**40%**	Improved stability
NI 146	NI 146 Adults with learning disabilities in employment	Percentage of People with a learning disability in settled accommodation	**10%**	**11%**	Increasing opportunity for employment

*based on our figures, but to be confirmed by the DoH

By: Graham Gibbens, Cabinet Member, Adult Social Services
Oliver Mills – Managing Director, Kent Adult Social Services

To: Adult Social Services Policy Overview Committee – 22 September 2009

Subject: **'INDEPENDENCE WELLBEING & CHOICE' INSPECTION**

Classification: Unrestricted

Summary:

1. The final report of the 'Independence Wellbeing and Choice' Inspection undertaken in March was presented to Cabinet by the Care Quality Commission on 13 July 2009.
2. This report outlines the main findings and presents the agreed Action Plan to address the recommendations of the report.

Introduction

1. (1) In March 2008, Kent Adult Social Services (KASS) was inspected as part of the national programme of 'Independence Wellbeing and Choice' Inspections. This report presents the main findings of the Inspection and the Action Plan agreed with the Care Quality Commission (CQC).

(2) The core theme of all the Inspections is 'Safeguarding Adults'. A further one or two themes are also chosen. In the case of Kent the theme of 'Delivering Preventative Services' with a focus on older people was selected. Outlined below are the reasons why Safeguarding is considered to be of such importance that it features as a core theme.

Impact of Safeguarding Adults

2. (1) Kent Adult Social Services (KASS) is accountable for safeguarding vulnerable adults in Kent, working with partners. This is laid out in the Department of Health Guidance 'No Secrets'.[1] In practice this means the arrangements in Kent are managed through the Kent and Medway Safeguarding Committee, which the Managing Director for KASS chairs. In summary, KASS has a lead responsibility to safeguard vulnerable adults from physical, sexual or financial abuse or neglect.

[1] The 'No Secrets' DOH guidance, March 2000 was issued under Section 7 of the Local Authority Social Services Act 1970

(2) Who is included under the heading 'vulnerable adult'?

- An Adult (a person aged 18 or over) who 'is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. (Definition from 'No Secrets' March 2000 Department of Health)

- This could include people with learning disabilities, mental health problems, older people and people with a physical disability or impairment. It may also include an individual who may be vulnerable as a consequence of their role as a carer in relation to any of the above. Their need for additional support to protect themselves may be increased when complicated by additional factors, such as domestic violence, physical frailty or chronic illness, sensory impairment, challenging behaviour, drug or alcohol problems, social or emotional problems, poverty or homelessness.

- Many vulnerable adults may not realise that they are being abused. For instance an older person, accepting that they are dependent on their family, may feel that they must tolerate losing control of their finances or their physical environment. They may be reluctant to assert themselves for fear of upsetting their carers or making the situation worse.

(3) There are important similarities between adult protection (safeguards) and child protection (safeguards). Both areas involve managing high risk, which can have devastating effects on individual's lives if things go wrong and with potential media impact. However, the framework of law is different, leading to more complex interactions for adults, and with no actual power to "take into care" in extremis, as exists for children. The need to safeguard vulnerable adults can occur in the community or in residential or hospital settings. A further dimension is where the wider community can be put at risk.

(4) Recently there have been a series of high profile adult safeguarding issues, which have come to the attention of the national media. Partly as a response to this and to ensure there are robust adult protection / safeguard processes in place across the country, the Commission for Social Care Inspectorate (CSCI) began in November 2007 a programme of inspections of all Local Authorities with Adult Social Care Responsibilities. In all these Inspections Safeguards has been a core theme. This programme has been carried on by the Care Quality Commission (CQC), which replaced CSCI on 1 April 2009. The personalisation agenda and the CQC approach to safeguarding vulnerable adult's means safeguarding will continue to be a high profile issue.

‘Independence Wellbeing and Choice’ Inspection

3. (1) The Inspection took place between 10th and 18th March 2009. There were two CSCI / CQC Inspectors. The lead Inspector was Silu Pascoe. There was also an expert by experience. The expert by experience is ‘someone with direct experience of relevant services’. The Audit Commission took the opportunity the Inspection gave to undertake some joint work with CQC, however they will be reporting separately on their findings.

(2) The themes Safeguarding Adults and Delivering of Preventative Services are rated in the following way:
- Poor (1), Adequate (2), Good (3) and Excellent (4).

(3) As well as the two themes outlined above the Inspection examined the domains of ‘Leadership’ and ‘Use of Resources’ under the heading of ‘Capacity To Improve.’ This is rated in the following way:
- Poor (1), Uncertain (2), Promising (3) and Excellent (4).

(4) The inspection followed a familiar format of a survey conducted by the inspectors, file audit, submission of documentation and self assessment, focus groups with service users and with carers, partners, staff as well as interviews and visits.

(5) The final report is usually published eight weeks after the fieldwork has been completed. Owing to the timing of the County Council elections publication of the report was delayed. The original timetable for publication of the report clashed with the period of purdah and therefore the earliest ‘appropriate public council meeting’ the report could be presented was Cabinet on 13 July 2009.

Main Findings

4. (1) The CQC concluded that Kent’s safeguarding of adults was **Good** and that delivery of preventative services in Kent was **Excellent**. The CQC also concluded that capacity to improve in Kent was **Excellent**.

(2) KASS was pleased that the report found that ‘the council and its partners’ gave ‘a high priority to adult safeguarding’ and that ‘once safeguarding alerts were made, risk was well managed and people were appropriately protected’. In addition, the report found that the council ‘has a clear focus on promoting the independence of older people and a strong emphasis on enablement and rehabilitation’. It was also noted that ‘the council had an ambitious and purposeful vision that was jointly owned by partner agencies. Its strategic direction and priorities were clear and the prevention agenda had been given a high priority. Political and managerial leadership was strong’.

(3) The Directorate welcomes the findings of the inspection and believes them to be positive and give a good insight into areas which can be improved.

Action Plan

5. (1) An Action Plan has been agreed with the Care Quality Commission, which is presented here (Appendix 1). The Action Plan has an internal monitoring process to support and report upon progress. Any issues associated with delivering the Action Plan will be reported to Cabinet Members.

(2) There are nine recommendations in total following the Inspection. Accountable leads have been assigned to each recommendation from Kent Adult Social Services and the Kent and Medway Partnership Trust (KMPT) and each has a Directorate Strategic Management Team sponsor.

(3) Work is currently underway on each of the nine recommendations to ensure that desired outcomes and timescales are met. East Kent, West Kent and KMPT have developed action plans based on the Inspection Action Plan agreed with the CQC, and these will be monitored by the respective management teams on a regular basis.

(4) Progress towards the Action Plan will be monitored at routine business monitoring meetings by the CQC. The progress will be formally reviewed at the next meeting in December 2009 which will involve our Area Manager, Carol Williams, and Lead Inspector, Silu Pascoe.

(5) As well as the major recommendations, the report through the text also suggests other areas where improvements can be made. To address these, the Directorate has developed an internal action plan which will be monitored with regular updates to the Directorate's Strategic Management Team.

Recommendations

6. (1) Members are asked to NOTE and COMMENT on the report and attached Inspection Action Plan.

Katherine Stephens
Senior Planning Officer
01622 694556

Nick Sherlock
Head of Planning and Public Involvement
01622 696175

Attached documents
Appendix 1 – 'Independence Wellbeing and Choice' Inspection Action Plan

Inspection Action Plan

1. Outlined below is the Action Plan which has been agreed with the Care Quality Commission following the Recommendations of the Independence Wellbeing and Choice Inspection.
2. The actions from this plan will be monitored closely by the Kent Adult Social Services Strategic Management Team and progress will be reported to Members on a regular basis though the established reporting processes.
3. In March 2010 a full evaluation of the Action plan will be undertaken and the outcomes will be reported to the Care Quality Commission, Members and the public.

Safeguarding Adults

Recommendation	Actions	Measurable Indicator	Desired Outcome	Timescale	Lead (s)
1. The council and its partners should develop a communications and engagement strategy that ensures people who use services, carers and members of the public know how to report abuse and know how to keep themselves safe	1. Review Public Involvement Strategy to Draft Engagement Strategy involving: Service users Carers members of public from a range of backgrounds 2. Further involve of the public (as outlined in 1) in development of the strategy 3. Ratified by SGVA Committee Monitor arrangements – key indicators to illustrate outcomes are being achieved 4. Need to link it to SDS, Business Strategy of Safeguarding Board (Business Strategy includes a Communications Strategy) 5. Liaise with partners 6. Compare awareness to national benchmarks 7. Record informal concerns raised 8. Campaign to raise the profile of safeguarding within the	1. Strategy in place 2. Implementation plan 3. Monitor agreed outcomes of implementation plan 4. Commission survey to determine if the public know how to report abuse 5. Increased referrals from diverse communities for other community based services 6. Public Information Strategy (as outlined in recommendation 6.)	1. Increased engagement with the community. A key feature of success would be increased involvement with diverse communities (evidenced by the public involvement database) 2. Increased awareness of safeguarding amongst the public (as established by survey Measurable indicator 4) 3. Increase in percentage of safeguard alerts from diverse	March 2010	ALFA Transforming Social Care Lead Director, Head Of Planning & Public Involvement KMPT: Head Of Comms Head of Safeguarding PPCI Manager Assoc Dir Social Care-east and Development team rep Head of E&D **SMT sponsor:** Managing Director

	community focusing on areas/groups of low representation		communities to be more representative of the demographic make up of Kent. *Evidence* – Quarterly Safeguards Activity Report to Cabinet Member Annual Report to Safeguards Board		
2. The council and its partners should develop an adult safeguarding workforce development strategy that includes a competency-based framework	1. Develop adult safeguarding workforce development strategy 2. Develop competency-based framework to be included in workforce strategy 3. Strategy and Framework agreed by SGVA Board 4. Implementation plan 5. Review mechanism 6. Ensure existing good practice is developed across all the County	1. Develop and implement Workforce Development Strategy implementation plan 2. Good Practice Board – analyse and compare practice audits and case examples across Localities 3. Audits action plan (audit of case files and supervisions)	1. Adult safeguarding workforce development strategy that includes a competency-based framework 2. Improved consistency of practice as measured by internal case audits. Overseen by Good Practice Group 3. Improved data quality as measured by SWIFT – evidence SWIFT audits	Oct 2009	Head of ALRT, Head of Personnel, Senior P&SS Manager – Safeguarding KMPT: Head of Safeguarding Lead Trainers-Ad P **SMT sponsor**: Director – Strategic Business Support

3. The council and its partners should analyse the high number of inconclusive outcomes of safeguarding alerts in order to inform future practice	1. Agree cohort of cases which meet this criteria 2. Data analysis of current ‘inconclusive cases’ 3. Audit a selection of cases 4. Analysis of findings 5. Action plan to address findings	1. Reports to AMTs to gain an understanding of the reasons behind inconclusive outcomes 2. Alerts with inconclusive outcomes	1. Understanding of issues and develop action plan to address them 2. Reduction in the number of safeguard alerts with inconclusive outcomes *Evidence* – Quarterly Safeguards Activity Report to Cabinet Member Annual Report to Safeguards Board	Jan 2010	Safeguards Co-ordinators, Senior P&SS Manager – Safeguarding, Head of Performance and Information Management KMPT: Head of Safeguarding **SMT sponsor:** Director – Strategic Business Support
4. The council should review both the need for and the capacity of advocacy organisations to support and empower people through safeguarding processes, especially during the investigative process or where support needs are long term	1. Review Advocacy Arrangements, particularly organisations used by people subject to safeguarding processes currently and in the future 2. Ensure this work is linked into SDS workstream	1. Identify and review Advocacy Agreements – coverage, quality, take up and clients served (LA/self funders)	1. Effective Advocacy support – especially re Safeguarding Investigations. As evidenced by the increase use of advocates in safeguard investigations. *Evidence* – Annual Report Feedback from people as captured by the Annual Complaints Report and SDS feedback	Jan 2010	Head of Policy & Service Standards, Strategic Commissioning Group KMPT: Head of Safeguarding Assoc Dir Social Care-east and Development team rep **SMT sponsors:** Director of Operations, Directors of

					Commissioning & Provision

Access to Preventative Services

Recommendation	Actions	Measurable Indicator	Desired Outcome	Timescale	Lead (s)
5. The council should work with family carers to develop better access to appropriate information, advice and services to support them in their caring role.	1. Implement Kent Carers Strategy 2. Deliver T2010 3. Involve Carers in public information strategy 4. Work with Health and Primary Care Practices to improve information and support 5. Carers Survey	1. Evidence of increased opportunities for carers in training 2. Carers Survey illustrating carers have increased access to information 3. Evidence of joint work with Health to improve information, advice and services	1. Feedback from carers and users of improved access to information, advice and support *Evidence* • Feedback through regular contact with carers • Feedback from Carer Organisations • Survey of carers All of the above will be reported in the Annual Carers Report	Jan 2010	P&SS Manager – Carers, Senior P&SS Manager, Area Leads KMPT: Head Of Comms PPCI Manager Head of E&D Assoc Directors (west and east) Older People Services **SMT sponsor:** Head of Policy & Service Standards
6. The council should implement a clear public information strategy that includes information distribution and improved signposting by staff to ensure that people are made aware of the range of preventative services available	1. Develop Public Information Strategy linked to SDS, Advice, Information and Guidance policy 2. Involve service users, carers, staff, partners and members of the public 3. Implement 4. Ensure staff through training and other mechanisms are aware of, and are able to	1. Feedback from service users, carers, members of public, staff, and partners	1. Implement Public Information Strategy (Communication Strategy) *Evidence* • Feedback through regular contact with public, esp. those using	March 2010	Directorate Manager for Communication, Governance and Member Support, Head of Planning & Public Involvement KMPT: Head Of Comms PPCI Manager

	implement effectively the policy 4. Monitor using feedback as outlined in measurable indicator		social care support • Feedback from partners – esp. Vol. Organisations • Survey of public showing improved access to information		Head of E&D Assoc Dir Social Care (east) and Development team rep **SMT sponsor:** ALFA Transforming Social Care Lead Director

Leadership and Commissioning

Recommendation	Actions	Measurable Indicator	Desired Outcome	Timescale	Lead (s)
7. The council should ensure that it monitors the outcomes for people signposted on to other services to inform commissioning plans	1. Develop a method of tracking outcomes which is effective and efficient to inform commissioning plans 2. Explore best practice, including other Local Authorities 3. Carry out a sample survey to inform effectiveness of commissioning plans 4. Ensure that feedback is linked into SDS Commissioning workstreams and linked into Information Advice and Support Policy	1. Feedback from public 2. Outcomes of surveys 3. Framework in place to capture outcomes	1. KASS has in place framework to capture outcomes 2. Outcomes are being used in JSNA and new commissioning/planning arrangements 3. This is an integral part of SDS planning	Jan 2010	Strategic Commissioning Group, SDS Project Managers, Head of Planning and Public Involvement KMPT: Assoc Dir Social Care (east) and Development team rep Assoc Directors (west and east) Older People Services PPCI Manager Head of E&D **SMT sponsors:**

					Director of Operations, Directors of Commissioning & Provision
8. The council should ensure that its diverse communities are effectively involved in commissioning processes so that services are sensitive to their needs	1. Ensure diverse communities are represented in Engagement Strategy 2. Ensure the outcomes from the Engagement Strategy work are fed into commissioning strategies 3. Up to date analysis of diverse communities in Kent– need to be part of future JSNA 4. Develop action plan to focus on diverse communities 5. Ensure that diverse communities are fully involved in the commissioning of new services 6. Develop capacity building in diverse communities with the voluntary sector	1. Feedback – satisfaction survey 2. Audit of service uptake 3. Service reviews 4. More people from diverse communities purchase own packages 5. People able to assist in producing support plans that are culturally appropriate 6. Review Culturally Competent Care 7. LGBT Care Guide 8. More thriving and diverse market place	1. Better access and take up of services / engagement with diverse communities *Evidence* • Increase take up of services by people from diverse communities	Jan 2010	Strategic Commissioning Group, Head of Planning and Public Involvement KMPT: PPCI Manager Head of E&D **SMT sponsor**: Directors of Commissioning & Provision
9. The council should ensure its partner agencies have a clearer understanding of the new self-directed support approach and build their capacity to flexibly respond to people's individual needs	1. Build upon steps already taken 2. Part of a SDS work stream 3. Involve partner agencies (including providers) in market shaping/market development re SDS 4. Ensure Partners & Public are fully involved in the continued development of SDS	1. Survey / feedback of those using SDS 2. A thriving social care market offering choice 3. Partner Agencies fully engaged in SDS model 4. Feedback from Partners & Providers	1. Full engagement in SDS from partners *Evidence* • Feedback from partners showing an increase in understanding of SDS objectives • Increase in the number of agencies taking active part in development of	March 2010	SDS Project Managers KMPT: Head Of Comms Assoc Dir Social Care (east) and Development team rep **SMT sponsor** ALFA Transforming Social Care Lead Director

			SDS • Increase in number of people taking up personalised packages of support • Feedback from people illustrating the availability of choice		

This page is intentionally left blank

By: Graham Gibbens, Cabinet Member, Adult Social Services
Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services Policy Overview Committee - 22 September 2009

Subject: **KASS POSITIVE RISK MANAGEMENT POLICY FOR STAFF CARRYING OUT COMMUNITY CARE ASSESSMENTS**

Classification: Unrestricted

Summary: This report tables the draft Kent Adult Social Services (KASS) Positive Risk Management Policy (Appendix 1) and Good Practice Guidance for staff carrying out Community Care assessments (Appendix 2).

It sets out how the Directorate intends to discharge its dual responsibility under Self-Directed Support (SDS) and duty of care for safeguarding vulnerable adults.

Introduction

1. (1) SDS, is the means by which adults eligible for social care support will exercise choice and control over how their needs are met. In practical terms it means giving people freedom to self assess (with support if required) and use their Personal Budget through Direct Payments or the Kent Card, to arrange their support services.

(2) There is a need to re-frame the policy because practitioners face a challenge in balancing the need to support service users and carers whilst at the same time ensuring that any risks to meeting outcomes are addressed. The policy is consistent with the corporate objectives in ‘Towards 2010’, ‘Policy Framework for Later Life’ and the KASS ‘Active Lives Strategy.

(3) The Chief Officers Group (COG) discussed the ‘Annual Report on Health and Safety, Events and Performance’ at its meeting on 3 September 2008. The Managing Director, KASS drew attention to the continuing responsibility for the safety of people who are taking more control of their services as part of the personalisation agenda. COG noted the ongoing dialogue between the Local Government Association (LGA), the Health and Safety Executive (HSE) and the Government about the need to adopt a reasonable approach to risk management. This has been reflected in the draft Risk Management Policy and Guidance.

(4) The policy satisfies the Key Decision criteria because of its far reaching implications that are “likely to have a “significant” effect on KCC’s services to the community “and “Adoption of major new policies, or changes to established policies” (Decision-Making Guidance for Officers).

(5) The policy has been included in the Forward Plan of Key Decisions for an Executive decision by the Cabinet Member for Adult Social Services.

(6) The policy was considered by the Directorate's Strategic Management Team (SMT) and COG on 13 March 2009 and 27 May 2009 respectively, as part of the approval process.

(7) The purpose of this report is to inform the Policy Overview Committee (POC) about the draft Policy and Good Practice Guidance (appendices 1 and 2), and take the opportunity to note its comments.

Background

2. (1) The draft Policy and Good Practice Guidance has been influenced by several publications.

(2) In October 2006, The Better Regulation Commission's Report "Risk, Responsibility and Regulation – Whose risk is it anyway"? called for a redefinition of society's approach to risk management, to recognise that within the right circumstances risk can be beneficial, balancing necessary levels of protection with preserving levels of choice and control.

(3) Both the Concordat ***"Putting People First"*** and the Department of Health's ***"Independence Choice and Risk"*** guidance emphasises the need for local authorities to support people to exercise choice and control over the services they receive and who provides them. Local Authority Circular (2009)1, ***"Transforming Social Care"*** sets out information that supports this change agenda;

(4) People have higher expectations of what they need to meet their own particular circumstances, wanting greater control over their lives and the risks they take. They want to be treated with dignity and respect and to have access to high-quality support services at the time they want it and according to their choice.

(5) In line with the principles set out in the White Paper, **"Valuing People: A New Strategy for Learning Disability for the 21st Century"**, there has been an increased focus on the management of risks to health and safety in social and health services.

(6) It is important that such risks are appropriately managed, balancing the risks of challenging behaviour against the risks of reduced quality of life. It is not an appropriate or achievable goal that the risk of challenging behaviour be completely eliminated.

(7) The overall vision therefore is of a Directorate moving towards a position of enabling service users and carers to shape their own lives through personally commissioned services.

How the Policy was developed

3. (1) The need for this policy and good practice guidance is driven by the development of SDS. The policy has been co-developed by service users and carers, staff and management teams. It has been benchmarked against other local authorities and KCC's Risk Management Toolkit. We believe this policy will assist practitioners to adopt a

reasonable, proportionate and justifiable approach in the identification, assessment and management of risks.

(2) Others consulted and/or involved:

- KCC's Corporate Health and Safety Manager
- KCC's Corporate Risk and Insurance Manager
- Independent Consultant, who supported planning for the Safeguarding Inspection
- Trade Unions via KASS Health and Safety Committee
- KCC Legal Services
- The Health and Safety Executive.

(3) An equalities impact assessment has been completed and we are satisfied that, if the policy is applied properly it should not disadvantage any particular groups. However, clearer guidance for staff and the public will reduce the likelihood of this occurring.

Next Steps

4. (1) Training programme for all relevant staff has been developed and training is being taken forward on a priority basis.

(2) Produce Information, Advice and Guidance for the public that includes essential information on this policy.

Recommendations

5. (1) Members of the Policy Overview Committee are asked to:

(a) **NOTE** and comment on the report.
(b) **ENDORSE** the recommendation that the document should be adopted as a KCC Policy.

Appendices:
Appendix 1: KASS Positive Risk Management Policy for staff carrying out Community Care assessments.
Appendix 2: KASS Practice Guidance for staff carrying out Community Care assessments

Background Documents:
Local Authority Circular (2009),Transforming Adult Social Care, Department of Health.
Business Risk Management Toolkit, Kent County Council.

Contact:

Michael Thomas-Sam
Head of Service Policy and Standards (Adults)

Derrick Douglas
Policy Officer
Policy and Service Standards

7000 4843 7000 4893

Kent County Council

KENT ADULT SOCIAL SERVICES

POSITIVE RISK MANAGEMENT POLICY

FOR STAFF CARRYING OUT COMMUNITY CARE ASSESSMENTS

DRAFT

Version	Date	Revision
0.1 Draft	04/11/08	Initial draft for review & comment by Practitioner Staff representatives
0.2 Draft	01/12/08	Revised at meeting of Practitioner Staff representatives
0.3 Draft	12/12/08	Revised after SDS executive meeting held on 12 December 2008
0.4 Draft	19/12/08	Revised following meeting of KASS Health and Safety team
0.5 Draft	10/02/09	Revised following meeting with Tony Benton, Consultant
0.6 Draft	24/02/09	Revised following meeting of Corporate Health and Safety manager
0.7 Draft	27/02/09	Amendments discussed at meeting of Practitioner Staff representatives
0.7 Draft	27/02/09	Conclusion of service user consultation exercise WK
0.8 Draft	02/03/09	Amendments discussed at meeting of EK AMT
0.9 Draft	05/03/09	Policy Development and Review Board meeting
10 Draft	12/03/09	Service user consultation meeting EK
11 Draft	13/03/09	Senior Management Team meeting (SMT)
12 Draft	08/04/09	Trade Unions (Health and Safety Committee meeting)
13 Draft	14/04/09	Amendments discussed at meeting of WK AMT
	27/05/09	Chief Officers Group (COG)
14 Draft	03/08/09	Revised following response from Legal Services

Mission Statement

Kent Adult Social Services is committed to supporting people to make informed choices to meet their needs and staff to address any risks to these choices, consistent with the directorate's responsibilities for safeguarding vulnerable adults.

"There is a proper dignity and proportion to be observed in the performance of every act in life"
(Marcus Aurelius, Roman Emperor, 2nd Century AD)

DRAFT

Contents

Section 1

1) Introduction

2) Why do we need a policy?

3) What do we mean by risk?

4) What do we mean by positive risk management?

5) Positive risk management and the Mental Capacity Act

6) Positive risk management and Safeguarding.

7) The stages of Positive Risk Management

8) Does positive risk management affect “duty of care”?

9) How does positive risk management fit with Health and Safety legislation?

10) Positive risk Management and the Human Rights Act

11) The role and responsibilities of service users and family carers.

12) Risk enablement panel

DRAFT

1 Introduction

1.1 People who receive social services want independence, choice and control over how, where and with whom they live their lives. They want services that take account of their strengths and are consistent, reliable and flexible. In particular, they want services that fit their desired outcomes as individuals. Self Directed Support (SDS) enables service users to decide the way the money used for their support is spent. In effect, services will be commissioned by the service user instead of the practitioner through personal budgets and direct payments, to help them to achieve the outcomes that matter to them.

1.2 Under SDS principles people are given opportunities regarding choice and control but as a public body KASS has a duty to ensure that people are properly informed and where vulnerable, protected in accordance with the directorate's Safeguarding Policy. Where there is a difference of views KASS will take all circumstances into account, including the best interests and safety of the vulnerable person, in reaching a decision.

1.3 Where there are risk(s) to the safety and wellbeing of service users and/or others, these have to be identified and managed. Staff must respect people's choices by offering them support to address the risk(s) and providing information advice and guidance on possible consequences, if they are not addressed. Dealing with risk(s) in positive ways gives service users more opportunities to enjoy their rights, fulfil their wishes and so improve the quality of their lives. In providing such support, staff must treat all people fairly regardless of race, gender, disability, age, sexuality and faith.

1.4 Positive attitude to risk must be balanced with the council's duty to have proper arrangements in place to protect the residents of Kent and to comply with the duty of care on safeguarding, care standards and health and safety.

1.5 This policy and guidance sets out the approach that all staff must apply when considering the issue of risk in working to support adults, including people who fund their own care, to achieve their desired outcomes. It builds on good practice and will increase the confidence of those practitioners who have to make decisions on the balance of risk and opportunity. The aim is to achieve a culture of positive awareness and responsibility for the assessment and management of risk at all levels within the directorate.

DRAFT

1.6 This policy and guidance applies to all staff within the Directorate including seconded staff, agency staff, temporary contracted staff and all private and voluntary sector contractors.

1.7 This policy is based on the principle of proportionate approach to risk management. Where presenting risks are considered low there may not be a need to work through a detailed risk assessment as set out in this policy. Conversely it should be used in cases where the risks are considerable and significant. All risk assessments must be **"suitable and sufficient"** in relation to the particular circumstances of the case.

2. Why we need a policy?

2.1 Self Directed Support means that people will choose to meet their needs in ways that are highly personal and sometimes different from those currently on offer from traditional services. Any risks which may flow from their chosen way of meeting their needs have to be evaluated and managed if their attempts to enjoy fulfilled lives are not to be frustrated. The policy will;

.

- Enable staff to develop a consistent approach to risk based on managing it, rather than avoiding it.
- Promote the development of new and positive ways to support and empower service users and family carers to live in the ways they choose.
- Enable staff to put service users and family carers at the centre of decision making with regard to the services they receive.
- Promote a "learning from experience" approach as a means of improving the overall quality of services.

3. What do we mean by risk?

3.1 Risk is the chance that an event may occur resulting in harm or loss for a person or others with whom that person comes into contact. The event should not be thought of in negative terms such as injury, danger, damage, loss or threat without also considering its potential benefits. Focussing only on what can go wrong can limit opportunities for trying something new or different that can really improve people's health and well being.

4. What do we mean by positive risk management?

DRAFT

4.1 Positive risk management involves working with service users and family carers to enable them to achieve the outcomes that matter to them. It is an approach to risk that supports people in thinking through the possible consequences, positive or negative, of any action or inaction. This enables people to make informed choices and accept responsibility for their decisions.

4.2 It is **neither** possible to get rid of all risk(s) and keep people safe at all costs on the one hand, **nor** appropriate to leave them to their own devices on the other. Staff must adopt a positive and consistent approach to risk at all times which balances the safeguarding of individuals, with support for service users and family carers in making their own decisions.

5. Positive risk management and the Mental Capacity Act

5.1 A positive approach to risk is a constant theme of the Mental Capacity Act, as indicated by the following principles.

- A person must be assumed to have capacity to make decisions unless it is proved otherwise.
- Individuals have a right to be supported in making their own decisions before anyone concludes that they cannot.
- Individuals must retain the right to make what appear as eccentric or unwise decisions.
- Anything done for or on behalf of people without capacity must be in their best interests.
- Anything done for or on behalf of people without capacity should be the least restrictive option.

5.2 A practitioner's first priority is to maximize a person's decision making capacity, by taking all practicable steps to support the person to make the decision for themselves. Any assessment of capacity must therefore be carried out, wherever possible, at the place and time of the person's highest level of functioning.

5.3 Where people do not have the mental capacity to consent to a specific decision at the relevant time when the decision needs to be made, practitioners have a duty under the Mental Capacity Act (MCA) 2005 to act in their best interests when deciding what services to support**.** If the person has family, friends or advocates the practitioner must consult them and any professionals involved, before reaching the best interests decision. They may also have to carry out risk assessments. The final

DRAFT

decision of the decision-maker must be made using the statutory framework for best interests decisions under the Mental Capacity Act.

5.4 The Deprivation of Liberty Safeguards (DOLs) apply to people who lack the capacity specifically to consent to treatment or care in a hospital or care home, under public or private arrangements. From April 2009, where a decision by a practitioner is likely to deprive a service user of his/her liberty, the practitioner must refer to the Supervisory Body (local authority or PCT) so that a series of six assessments, including a Best Interests Assessment, can be carried out in accordance with procedures.

5.5 Based on that assessment the Best Interests Assessor (BIA) will recommend that any action to restrict the service user's liberty must be carried out in the least restrictive way. The Supervisory Body will authorize the deprivation of liberty for the shortest time possible, taking on the recommendation of the BIA and providing the person meets all the other qualifying assessments.

5.6 As an authorisation under DOLS can only apply to a person in a hospital or care home, an application must be made to the Court of Protection if deprivation of liberty takes place elsewhere. Apart from the authorisation of deprivation of liberty under DOLS as set out above, deprivation is prohibited unless the Court has made an order concerning the person's personal welfare, or where it is authorised for life-sustaining or other emergency treatment.

5.7 It is the responsibility of the practitioner and the BIA to ensure that the deprivation of liberty safeguards is operated fairly and equitably in line with the Directorate's Equalities Policy.

DRAFT

6. Positive risk management and Safeguarding

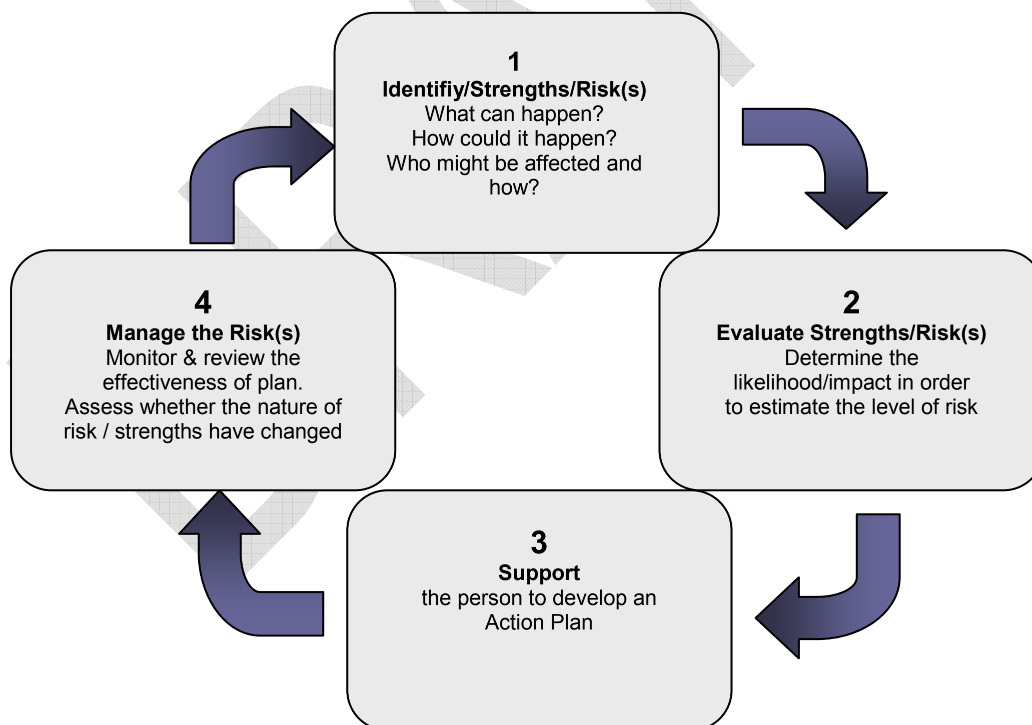
6.1 KASS has a responsibility to ensure that safeguarding issues are taken into account at every stage of the assessment, support planning and co-ordination of services. Safeguarding issues can present as physical abuse, sexual abuse, psychological abuse, financial abuse, neglect and acts of omission, discriminatory abuse, institutional abuse, domestic violence and self-neglect, or a combination of any of these.

6.2 Staff should bear in mind that positive risk management should be proportionate and any response should relate to the type of arrangements the individual chooses.

6.3 Where a person's agreed outcomes are not being met, or the way in which they are being met raises issues of legality or likely harm, a proportionate response will have to be initiated. See Kent and Medway Multi-agency Safeguarding Policy and Procedures. Internet link - *http://www.kent.gov.uk/publications/social-care-and-health/ap-pols-procedures.htm*

7. The stages of Positive Risk Management

7.1 The chart below shows the four stages (Identify Strengths/Risk(s), Evaluate Strengths/Risk(s), Support the person to develop Action Plan and Manage the Risk(s)) of Positive Risk Management. It reflects an ongoing process of assessment and review.



Adapted from Kent County Council Business Risk Management Toolkit: Revised 2008

8. Does positive risk management affect "duty of care"?

DRAFT

8.1 "Duty of care" requires KASS to take reasonable care to avoid any action or omission which it can reasonably foresee would be likely to result in harm or loss to a service user, family carers, staff or the general public. The responsibility which staff have to enable people to make informed choices and decisions, as well as to take appropriate steps to minimise any foreseeable risk(s) by involving the person and where necessary, others who know and support them, must be exercised with this duty always in mind. This is positive risk management in action. Where a service user can make a decision with or without support, the process of risk assessing enables the practitioner to establish the level of risk through discussion and exchange of information with service users an/or their representative. This will include advice on how the risk(s) can be addressed.

8.2 If the person chooses not to accept the advice and decides to live with a level of risk to themselves, they are entitled to do so, provided it is legal. The law will treat that person as having consented to the risk. However, staff must continue to act responsibly by discussing the case with their manager or supervisor, informing others involved on a "need to know" basis, monitoring the situation and letting the service user or carer know that they can contact KASS in the event that they need further support or guidance. (see item 5 above on the Mental Capacity Act and if necessary, consult the Mental Capacity Act Guidance).

8.3 Where a practitioner has acted reasonably i.e. has clearly communicated and recorded the advice to the service user and/or carer in accordance with case note recording guidance and raised the matter in supervision in accordance with supervision policy, they would have met their "duty of care" to the service user or carer and established a clear audit trail. Any legal liabilities will only arise where a "duty of care" has not been met through negligent acts or omissions by staff which result in injury or loss. Staff must therefore record the events in sufficient detail in all circumstances.

9. How does positive risk management fit with Health and Safety Legislation?

9.1 KASS has a duty to protect the health and safety of its staff and other people with whom they are involved, as far as is reasonably practicable. This is reinforced by staff training. Positive risk management will not change Health and Safety policy and guidance.

9.2 As with "duty of care" staff must not use Health and Safety policy and guidance to block reasonable activity. A risk assessment will determine whether the risk(s) can be managed. Any control measures identified will help to protect people from harm as they pursue their activities.

DRAFT

There will be occasions when the level of risk is so great that KASS will not be able to support the activity. In such situations staff must clearly document and communicate the reasons for their decision to all involved.

10. Positive Risk Management and the Human Rights Act

10.1 Article 8 of the Human Rights Act refers to the "right to respect for private and family life, home and correspondence". These rights are not absolute as they have to be balanced against the rights of others such as care workers or residents of a care home who in certain situations may be exposed to unacceptable risk(s) of injury or harm. Risk assessments are therefore essential to determine if or how to proceed in circumstances where there may be conflict between the rights of a service user or carer under the Act and that of others. Any interference with article 8 must be justified, proportionate and clearly recorded and communicated as appropriate

11. The role and responsibilities of service users and family carers

11.1 While service users should as far as possible exercise their right to choose the support they require to achieve their best outcomes, they also need to understand the consequences of their choice and take responsibility for them. This also applies to family carers or those acting for service users who do not have the capacity to make their own decisions. Some people may not want to accept responsibility if something goes wrong, so it is important that practitioners, service users and family carers work together to identify and manage risk(s) and keep accurate records of discussions and decision-making processes. This will promote a culture of positive and responsible decision-making.

Service users and family carers would be expected to;

- Follow the risk action plan agreed with the practitioner or other staff and consult them promptly if they find it difficult to stick to the agreement.
- Work with staff to regularly re-assess or review a risk management action plan, ongoing needs and how those needs can be met.
- Inform staff about any changes to their circumstances which they feel may affect the level of risk positively or negatively. This is particularly vital in situations where people's medical conditions are likely to fluctuate.

DRAFT

- Where appropriate, co-operate with other agencies such as the NHS or voluntary organization that provide services as part of the action plan.

11.2 Where service users choose to purchase services using personal budgets or direct payments, KASS has a duty to make payments to them to enable them to meet their needs, minus any financial contribution. Service users or their representatives must, however, act responsibly by ensuring that providers of services are competent to meet the agreed outcomes. KASS's Care Services Directory is available to assist the service user or their representative in choosing a competent service provider.

11.3 See Good Practice Guidance for staff carrying out Community Care assessments (appendix 2), which includes a section on the proper use of Personal budget and Direct Payments.

12. Risk Enablement Panel

12.1 In exceptional circumstances, where the risk issues associated with the support option(s) chosen by the service user are considered too complex and challenging and the team manager or supervisor is unable to negotiate an agreement with the service user, the case will be escalated for consideration by a Risk Enablement Panel, one of which will be established in each of the 6 Localities in Kent.

The purpose of the Panel:

- To seek positive solutions and outcomes for individuals by resolving disagreements about how to address complex and challenging risk decisions.
- To reassure practitioner staff that they will not be left to make complex and challenging decisions without appropriate support from senior managers.
- Provide support guidance and direction to staff.
- To demonstrate that the Directorate has fulfilled its duty of care around the support of service users, carers and staff.

12.2 Each locality Risk Enablement Panel will be chaired by a Head of Service of another locality in the interest of objective decision making. Health and Safety and Safeguarding representatives will have permanent seats with others attending as necessary.

DRAFT

12.3 The panel will be convened as and when necessary following a referral, reflecting the need to respond in a flexible and timely manner to all referrals. In future, it may be necessary to formally schedule its sittings if it emerges that the referrals it receives will be better managed this way.

12.4 Referral to the Panel will be via the Locality Support Manager who will have a co-ordinating role in organizing the hearings.

12.5 The Panel is not a substitute for team level decision making. It is the responsibility of the team manager to ensure that the cases referred to the Panel have been subjected to robust attempts to resolve them at team level.

12.6 The Panel will consider each case and clearly record its discussions, decisions and the reasoning used in reaching those decisions. It is also responsible for ensuring that the information is placed in the service user's file.

12.7 The manager and practitioner will be responsible for acting on the advice and/or implementing the decisions recommended by the Risk Enablement Panel.

DRAFT

Kent County Council

KASS GOOD PRACTICE GUIDANCE FOR

STAFF CARRYING OUT COMMUNITY CARE ASSESSMENTS

DRAFT

1.1 KASS has to maintain at all times a delicate balance between empowerment and safeguarding; choice and risk. It is essential for practitioners to consider when the need to protect people from harm overrides the obligation to promote choice and empowerment. The following guidance aims to improve decision-making in this regard to enable service users to achieve the outcomes that matter to them.

2.1 WORKING THROUGH THE 4 STEPS OF THE POSITIVE RISK MANAGEMENT PROCESS

Step 1: Identify Strengths/Risk(s)

Step 2: Evaluate Strengths/Risk(s)

Step 3: Support the person to develop an Action Plan

Step 4: Manage the Risk(s)

Step 1: Identify strengths and risk(s)

STEP 1	**Find out what factors will have an impact or effect on the risk(s).**
• Allocate cases to practitioners with the appropriate level of knowledge, experience and skills to carry out risk assessments based on the complexity of the issues. • Find out what the service user wants to do (or not do) and the outcomes they are seeking.	
• If communication with the service user is not possible because of their mental capacity, language or culture, you must provide support to obtain the information. e.g. a British Sign Language (BSL) interpreter for someone who is deaf.	
• You must compile information about the service user that is relevant, accurate, current and sufficient for the purposes of your assessment. If appropriate, consult past records, note any conflicting information and seek clarification as soon as practicable. • Make sure your assessment is "**suitable and sufficient**" in the particular circumstances of the case.	
• If you identify a safeguarding issue because you consider that the service user is in a vulnerable situation then raise an alert in line with the Kent and Medway Multi-agency Adult Protection Policy, Protocols and Guidance.	
• Record the risk(s) clearly and separately along with any related strengths or opportunities, and identify the effect they may have on the outcome which the service user seeks. • State what can happen, how it can happen, and who might be affected.	

DRAFT

Step 2: Evaluate Strengths/Risk(s)

STEP 2	The next task is for you to weigh up the impact and likelihood of the risk(s). Complete this step using the template below

- Make sure you involve all the relevant people i.e. service user, carer, advocate.
- Take account of any relevant environmental factors and where necessary, alert the appropriate agency.

- Use risk assessment template (below) to determine the likelihood (chance of the event occurring) and impact (level of harm) that might result from each risk.

Likelihood							
	Very likely		5 Low	10 Medium	15 Medium	20 High	25 High
	Likely		4 Low	8 Medium	12 Medium	16 High	20 High
	Possible		3 Low	6 Low	9 Medium	12 Medium	15 Medium
	Unlikely		2 Low	4 Low	6 Low	8 Medium	10 Medium
	Very Unlikely		1 Low	2 Low	3 Low	4 Low	5 Low
RISK RATING MATRIX			Minor	Moderate	Significant	Serious	Major
			Impact				

Adapted from Kent County Council Business Risk Management Toolkit: Revised 2008

LOW	MEDIUM	HIGH
1 - 6	8 – 15	16 - 25

- Use scores to determine the rate of response with high risk(s) being addressed as a priority.

- Bear in mind any safeguarding issues that might affect the risk rating.

- Bearing in mind any strengths and opportunities linked to service user outcomes, rate the risk(s) using the template.

DRAFT

• You must ensure that the service user and/or carer fully appreciates and genuinely understands the consequences of the risk(s) to enable them to make their best decisions.
• Note that in some cases it may be acceptable for you to accommodate a high level of short-term risk to achieve long-term gains for the service user, provided a clear and well-reasoned case can be made to support the decision and authorisation is obtained from your manager.
• If the risk assessment reveals that an event is likely to occur that will be extremely harmful to the health and safety of the service user, carer, staff or the public, take immediate steps to address the risk(s) by alerting the Health and Safety representative. • You must advise all those involved of the potential harmful event and the need to cease any activity (or inactivity) which might cause it to occur or increase its possible impact
• Use the Supported Decision Tool (Appendix 1) if necessary to establish if the risk is acceptable to the individual and/or carer. • Find out if the risk is unacceptable or if it places the Council in an unlawful position by discussing the case with your manager or supervisor.
• Managers and supervisors must guide and support practitioners in borderline, challenging or complex cases to strike the right balance between safeguarding people and supporting them in achieving their desired outcomes.
• You must consider any children who may be young carers of an adult and who could be at risk. • Work with the Children Families and Education (CFE) directorate to produce an action plan that meets the outcomes of all concerned while managing risk.

DRAFT

Step 3: Support the person to develop an action plan

STEP 3	**You now need to place the service user and/or their carer at the centre of action planning by supporting them to make decisions that address the risk(s).**
• Provide information about services and community resources that is clear, accessible and of high quality. • Use appropriate interpretation and advocacy services to communicate the information to those people with language or sensory needs. • Support people in looking at all options to manage the risk(s) and achieve their outcomes, even if they differ from the options you would have chosen. • Record and communicate discussions and negotiations in service user's case notes.	
• You must seek professional input and work with other agencies as appropriate i.e. in complex and challenging cases.	
• Where the person has been assessed as lacking capacity, you must always act in their best interest when reaching decisions on the actions that are needed to address the risk(s).	
• Allow sufficient time for service user and/or carer to decide which actions they are willing to support to manage the risk(s), even if it means putting in place interim measures to address the risk(s). • Record the details in case notes and discuss the matter in supervision.	
• If people choose not to accept your advice or decline offers of support and decide to live with a level of risk to themselves that is not illegal, you should make sure that they understand the level of risk, but they cannot be coerced into acceptance. • You must discuss the case with your manager or supervisor, inform others involved on a "need to know" basis, monitor the situation and provide the service user or carer with contact details in case they change their mind.	
• Draw up the action plan, involving the relevant people. • Ensure each person's role in delivering the plan is clearly understood and accepted. • Agree what actions need to be taken, when they will be taken, who will take them and the outcomes that are being sought. • Decide the implementation date and record any disagreements.	

DRAFT

Step 4: Manage the risk(s)

STEP 4	**Finally, you have to manage the risk(s) by implementing, monitoring and reviewing the action plan.**
• Implement the action plan promptly in accordance with the risk level. • Agree how and when it will be reviewed, who will carry it out and who else will be involved. • Carry out reviews within 3 months of the service starting and annually thereafter. • Depending on the risk level, reviews may be more frequent. • Clearly record the details in service user's case notes and share copies of the action plan with those involved.	
• Ensure the review is proportionate to the risk level. • Self-review may be more appropriate than a full and comprehensive review. • The following is a guide for carrying out reviews proportionate to the level of risk: Low = Monitor via telephone call, texting, self-review, etc Medium = Face to face review, further risk reassessment if necessary High = Face to face, full and comprehensive review, reassessment if necessary, regular monitoring.	
• You must monitor progress of the action plan, make quick changes to previous decisions if required and intervene in a more restrictive way if necessary. • Avoid policing people's decisions unless there are very good reasons for doing so. Record the reasons in service user's case notes.	
• You must discuss with your supervisor or manager any post-implementation disagreement and seek to achieve a quick resolution. • Managers and supervisors are jointly accountable for decisions associated with positive risk management.	

DRAFT

- Encourage service users and carers who directly employ support workers to take up Criminal Record Bureau (CRB) or Independent Safeguarding Authority (ISA) checks of their suitability for employment.

- Offer KASS's support in obtaining the required information as individuals are unable to apply directly for CRB and ISA checks.

- Use review to find out if the actions to reduce the risk(s) have been effective and to what extent.
- Find out from service user and/or carer if their outcomes have been or are currently being met and to what extent.
- Share the result of the review with those involved.
- Amend the action plan accordingly.

- If a full reassessment is necessary, identify the strengths and risk(s) and follow the Good Practice Guide once again.

- Attend training in Positive Risk Management as part of continuing professional development. This will help to develop a culture where the appropriate balance is achieved between the need to meet service user's outcomes and the directorate's duty to safeguard vulnerable adults.

DRAFT

3 The use of Personal Budgets and Direct Payments

KASS will provide Personal Budgets to people who meet the Fair Access to Care Services (FACS) eligibility criteria for non-residential services. A Personal Budget may be taken as a Direct Payment, with conditions in certain circumstances. The Directorate has to ensure the proper use of the council's monies. The table below is a guide to staff on the proper use of Personal Budgets and Direct Payments, to meet needs identified in the support plan.

The support plan **will** be agreed if the Personal Budget or Direct Payments will be used to fund the following;	The support plan **may** be agreed, subject to conditions laid down by KASS, if the Personal Budget or Direct Payments is to be used to fund the following:	The support plan **will not** be agreed if the Personal Budget or Direct Payments will be used to fund the following;
• Services from a person or private sector agency that is competent to provide it, including equipment and minor adaptations. • Services from Voluntary Sector agencies, other than those services currently being funded under agreements or contracts with KASS • Other arrangements that will demonstrably achieve the agreed outcomes	• Short periods of respite and some specialist equipment • Services from a spouse, partner or relative due to: - reasons relating to service user's religious practice or belief, - actual or potential inability to secure services from people in the local area, - communication needs of the service user which cannot be met in the local community areas, including British Sign Language (BSL), - a family emergency or event e.g. funeral or sickness requiring "one off" stays away from the home. • Services directly provided by KASS. A Personal Budget can fund these but a Direct Payment may not	• Residential or nursing care other than short periods of respite and some specialist equipment. • Services that will not meet outcomes agreed with KASS e.g. a gift for a carer. • Services which district and borough councils currently have a duty to provide. • Services that Health is responsible for providing e.g. NHS Continuing Healthcare. • Support from someone who might put you or others members of the public at risk. • Anything that is illegal

DRAFT

4 Appendices

Appendix 1

A Supported Decision Tool

This tool is designed to guide and record the discussion when a person's choices involve an element of risk. It will be particularly helpful to a person with complex needs or if someone wants to undertake activities that appear particularly risky. (**It can be amended to suit different service user groups)**
It can be completed by the practitioner with the person or by the person themselves with any necessary support, (including the use of communication aids/pictures where necessary). It is important that, in discussing any risk issues, the person has as much information as possible (in an appropriate form), fully appreciates, and genuinely understands any consequences, to enable them to make their best decisions.
The tool could be adapted for use within existing needs assessment and care planning processes. It also has potential application for any organization or individual providing advice and support services to people who are self-funders and ineligible for support from their local councils.

Using the tool – Practitioners need to:

- Ensure that the person has the right support to express their wishes and aspirations
- Assume capacity unless otherwise proven
- Consider the physical and mental health of the person and any specialist services they need or are already receiving

Issues for the practitioner to consider
When using the tool with the individual, consider carefully the following aspects of the person's life and wishes:

- dignity
- diversity, race and culture, gender, sexual orientation, age
- religious and spiritual needs
- personal strengths
- ability/willingness to be supported to self care, in terms of:
- opportunities to learn new skills
- support networks
- environment - can it be improved by means of specialist equipment or assistive technology?
- information needs
- communication needs - tool can be adjusted (braille, photographs, simplified language)
- ability to identify own risk(s)
- ability to find solutions
- least restrictive options
- social isolation, inclusion, exclusion
- quality of life outcomes and the risk to independence of 'not doing'.

DRAFT

Supported decision tool

1. What is important to you in your life?	
2. What is working well?	
3. What isn't working so well?	
4. What could make it better?	
5. What things are difficult for you?	
6. Describe how they affect you living your life.	
7. What would make things better for you?	
8. What is stopping you from doing what you want to do?	
9. Do you think there are any risk(s)?	
10. Could things be done in a different way, which might reduce the risk(s)?	
11. Would you do things differently?	
12. Is the risk present wherever you live?	
13 What do you need to do?	
14. What does staff/organization need to change?	
15. What could family/carers do?	
16. Who is important to you?	
17. What do people important to you think?	
18. Are there any differences of opinion between you and the people you said are important to you?	
19. What would help to resolve this?	
20. Who might be able to help?	
21. What could we do (practitioner) to support you?	
Agreed next steps-who will do what	
How would you like your care plan to be changed to meet your outcomes?	
Record of any disagreements between people involved	
Date agreed to review how you are managing	
Signature Signature	

DRAFT

Appendix 2a

KASS POSITIVE RISK MANAGEMENT RISK RATING FORM

Likelihood						
	Very likely	5 Low	10 Medium	15 Medium	20 High	25 High
	Likely	4 Low	8 Medium	12 Medium	16 High	20 High
	Possible	3 Low	6 Low	9 Medium	12 Medium	15 Medium
	Unlikely	2 Low	4 Low	6 Low	8 Medium	10 Medium
	Very Unlikely	1 Low	2 Low	3 Low	4 Low	5 Low
RISK RATING MATRIX		Minor	Moderate	Significant	Serious	Major
Impact						

Use risk assessment key to determine the possible impact (level of harm) that might result and the likelihood (chance of the event occurring) from each risk.

Risk Rating

LOW	MEDIUM	HIGH
1 - 6	8 – 15	16 - 25

Risk Level	Action and Timescale
Low	No additional measures are required; however you must monitor to ensure that the risk(s) remain acceptably low.
Medium	Take prompt action to address the risk(s). Timescales must be consistent with the complexity of the issues and the likely impact on service users and others if action was delayed.
High	Take immediate steps to address the risk(s).

This risk rating form must be used with the risk evaluation form (see reverse) to calculate the overall risk score and risk level. Where there are multiple risks the overall risk level will be determined by the highest risk score.
This form must be used to develop the detailed action plan and be placed in the service user's case file.

DRAFT

Kent County Council

Appendix 2b

POSITIVE RISK MANAGEMENT RISK EVALUATION FORM

Service User name:……………………………… Service User ref:…………… Risk Score:…… Overall Risk Level…………..

Assessor's name (print):………………………….. Assessor's signature…………………… Date of Assessment………………...

Define risk (Describe it)	Evaluate risk	Risk Score	Actions to address risk	Resulting score	Monitor and review
give a brief description	Weigh up the strengths, opportunities and protective factors with the impact and likelihood of the activity/inactivity	20	List actions	8	Describe how you will monitor and how frequent (in proportion to risk)

DRAFT

Kent County Council

Appendix 3

KASS POSITIVE RISK MANAGEMENT GOOD PRACTICE MINI GUIDE

Step 1 Identify strengths/risks	Step 2 Evaluate strengths/risks	Step 3 Support the person to develop an action plan	Step 4 Manage the Risk(s)
You must ensure the service user has the right support to communicate their wishes and aspirations Find out what the service user wants to do (or not do) and the outcomes that matter to them. Find out their strengths (e.g. highly motivated, very good insight) and opportunities (e.g. to learn new life skills) Identify the risks (What can happen, how can it happen and who can be affected?)	You must involve all the relevant people. Take account of any relevant environmental factors and where necessary, alert the appropriate agency. If the service user is about to move to a different environment assess that too. Consider any identified strengths and/or opportunities plus any safeguarding issues when deciding the risk level. You must consider Health and Safety issues and raise an alert if there is potential for extreme harm. Involve all the relevant people in deciding the risk level and record any disagreement. Use Positive Risk Management Risk Rating form to decide the risk level. Retain copy on case file. Discuss the case in supervision and obtain support and authorization for your decision. You must record details of the risk assessment in the case file.	Find out if things could be done differently to reduce the risk(s) level. If so, what? You must provide information about services and community resources to enable service to choose how to reduce risks to acceptable levels. Work in a multi-disciplinary and/or multi-agency way particularly in complex and challenging cases. Depending on the risk level, allow service users sufficient time to consider the options. Do not leave people exposed to risks that are illegal or places others in vulnerable situations. If in doubt consult. Always act in the best interest of the service user. You must draw up action plan with involvement of all the relevant people. Note and record any disagreement. You must discuss action plan in supervision and obtain managers support. You must ensure that Personal Budget and/or Direct Payments is at a level that enables the service user to purchase the services required to reduce the risk rating to an acceptable level.	You must co-ordinate the implementation of the action plan. You must monitor the action plan in proportion to the risk level and by the most appropriate means. You must review the action plan after 3 months and annually thereafter, but you can schedule them more frequently depending on the risk level. You must make quick changes to previous decisions if required and intervene in a more restrictive way if necessary. You must record monitoring and review details in service user case notes. You must find out if the actions to reduce the risk(s) were successful and to what extent. You must find out if service user outcomes have been, or are being met and to what extent. Revise the action plan or reassess if necessary.

DRAFT

Acknowledgements

1. Department of Health: Independence Choice and Risk: A Guide to Best Practice in Supported Decision Making 2007.

2. HM Government 2007: Putting People First: A Shared Vision and Commitment to the Transformation of Adults Social Care.

3. Cumbria County Council: Positive Risk Taking Policy “From Risk Aversion to Risk Management” 2007.

4. Gateshead Council: Positive Risk Taking Policy 2008.

5. Department of Health: The NHS Constitution, “the NHS belongs to us all”

6. KCC Business Risk Management Toolkit (Revised 2008)

DRAFT

By: Overview, Scrutiny and Localism Manager

To: Adult Social Services Policy Overview Committee
22 September 2009

Subject: **UPDATE ON SELECT COMMITTEE WORK**

Classification: Unrestricted

Summary: This report updates Members on the process for approving a Select Committee Topic Review Work Programme.

Select Committee Topic Review Work Programme

1. (1) As part of the spring and summer cycle of POC meetings, Members were asked to submit suggestions for topics for Select Committee Topic Reviews.

(2) The suggestions received will be subject to an assessment process, part of which will include seeking the comments of the Directorate and Cabinet Members, in order to assist the Policy Overview Co-ordinating Committee (POCC) to agree a Work Programme that adds value for the residents of Kent. The POCC will meet on 16 October 2009 to consider all suggestions for Topic Reviews, and the proposer will be invited to the POCC meeting to put forward their suggestion, supported by officers from the Directorate and, if appropriate, the Cabinet Member. Any Member who would like to have more information about the assessment process or requires a copy of a form should, in the first instance, contact Theresa Grayell, who supports this POC.

(3) The Committee is reminded of the recent decision of the County Council that, once a Topic Review has been included in the Work Programme, as agreed by the POCC, the detailed Terms Of Reference of each review will be developed by a cross-party Member Group (one from each Group) for approval by the Select Committee.

(4) Currently, the topics put forward which fall within the remit this POC are ‘Dementia’ and ‘Safeguarding and Adult Protection’.

(5) Following the meeting of the POCC on 16 October 2009, Members will be informed of the agreed Select Committee Topic Review Programme and, specifically, progress with any topics included which fall within the remit of this POC.

Recommendation:

2. Members are asked to note the process for agreeing a Select Committee Topic Review Programme.

Theresa Grayell, Democratic Services Officer,
Tel No: 01622 694277

e-mail: theresa.grayell@kent.gov.uk

Background Information: *Nil*